

Standpoints on Psychiatric Deinstitutionalization

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## ABSTRACT

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Between 1955 and 1985 the United States reduced the population confined in its public mental hospitals from around 600,000 to less than 110,000. This dissertation provides a novel analysis of the movement that advocated for psychiatric deinstitutionalization. To do so, it reconstructs the unfolding setting of the movement's activity historically, at a number of levels: namely, (1) the growth of private markets in the care of mental illness and the role of federal welfare policy; (2) the contested role of states as actors in driving the process by which these developments effected changes in the mental health system; and (3) the context of relevant events visible to contemporaries.

Methods of computational text analysis help to reconstruct this social context, and thus to identify the closure of key opportunities for movement action. In so doing, the dissertation introduces an original method for compiling textual corpora, based on a word-embedding model of ledes published by *The New York Times* from 1945 to the present. The approach enables researchers to achieve distinct, but equally consistent, actor-oriented descriptions of the social world spanning long periods of time, the forms of which are illustrated here.

Substantively, I find that by the early 1970s, the mental health system had disappeared from public view as a part of the field of general medicine — and with it a target around which the existing movement on behalf of the mentally ill might have effectively reorganized itself. Drawing together the case and the method, conceptually, is the idea of a standpoint: a framework within which objects obtain significance.

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## INTRODUCTION

I began this project fascinated with a social movement that seemed to be winning until it lost. Following the end of the second World War, reformers called for America to reduce reliance on its vast mental hospital system. During the 1960s the movement oriented to that goal appeared to move from strength to strength: Here, just moments after the involuntary commitment laws are repealed, we see ex-mental patients standing in solidarity with their Gay Liberation allies! Now we watch them campaigning, alongside the Black Panthers, for an end to electroshock treatment. And yet a moment later, it seemed, the same movement was abetting its own demise—working against the interests of the mentally ill, the people it was supposed to liberate. While *ex ante*, deinstitutionalization appeared as an unquestionable expansion of human freedom, *ex post* it appeared as an abdication of public responsibility.

But when I looked more closely into the history of the deinstitutionalization movement, there seemed to be “nothing but change”<sup>1</sup> — only variety, and only continuity. Looking at the movement itself gave little clue as to when things changed, or why. There was no centralized national organization leading the charge on behalf of the mentally ill. There was thus no single creature to accuse of having become corrupt, or submitting to the iron law of oligarchy. Different more-and-less organized groups worked together at different times, their relationships shifting kaleidoscopically. It turned out that these elements were often disarticulated in practice, if aware of one another at all, participants regarded each other from

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<sup>1</sup> Harlem Shakes, 2008.

a distance. Nor did their shared mission “creep”: this shifting set of protagonists called for less stigmatizing, less restrictive social responses to mental illness. In fact that goal was largely realized. They got it.

Could social science account for the transformation of the mental health movement? There are all sorts of ways of denying the problem: One could say that there wasn’t really any movement at all—the apparent “movement” was no more than rhetoric, without basis in real resources and power. Or one could observe that unintended consequences occur all the time. And whose intentions are we worrying about anyway, since really, there wasn’t any movement actor worth the name?

These objections felt to me unsatisfying. For one, they seemed no less applicable, *a priori*, in instances where social scientists take collective action seriously. The organizational features of the deinstitutionalization movement could equally be observed in other cases where scholarship has elevated movement activity as historically significant, causally relevant, and worthy of careful analysis.

Denial unsatisfying on another level too: The ground doesn’t just shift under feet the feet of individuals. It shifts at particular *moments*, under the feet of contemporaries—organizations, groups, actual and possible coalitions—differently positioned on a single historical plane. Dismissing unintended consequences as “merely” subjective seemed blind to the way that changes in the social world could systematically produce them.

Sociology's existing theoretical approaches to social movement activity did not seem to give adequate purchase on what had happened to the movement on behalf of the mentally ill at midcentury. History appeared to be missing. The classical view of movements as rational actors was missing it, and in a different way, the more recent literature on social movement fields was missing it too.

The first approach explained movement action as the outcome of interests—themselves ascribed to either organizations, or the groups for whom they claimed to speak. This route landed in denial: if the actor had not gotten what it wanted, well, it must not have been a very good actor to start with. The second perspective wanted to restore movement activity to the landscape of meaning in which it was undertaken, which seemed more promising. But as much complexity as the field-theoretic approach was prepared to admit, it did not seem to offer a systematic way of relating “meanings-at-the-time” for movement makers to the significance of their actions in historical retrospect. Fascinated as this scholarship was with shared identity, it did not appear interested in collective *action*.

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This project thus represents an attempt to take the movement on behalf of the mentally ill seriously as an actor. But the dissertation actually focuses very little attention on those individuals and groups that advocated for community mental health, the conscientious

objectors sent to work in mental hospitals who called for reform after war, or the anti-psychiatrists, or the ex-patients' collectives, or the civil libertarian allies. It devotes little direct attention to those organized on behalf of the mentally ill, the things they did, or how they presented themselves—the stuff of social movement studies. I return to these subjects only at the very end of the dissertation. What I focus on instead is reconstructing the circumstances and the available social context in which the movement moved. It is within that frame that it becomes possible to see, and to understand movement action.

I present deinstitutionalization as a case of historical reversal. The aim of reducing reliance on mental hospitals, first defined by a coalition of mental health reformers following World War II, was *objectively* transformed by changes in the social world. I do not simply mean that deinstitutionalization initially appeared to many as a success, and was subsequently reassessed as a failure— although that is also true. Rather, I mean that in the late 1940s, the proposition that US society should reduce reliance on its mental hospitals would have had one set of economic and social implications for the set of parties involved—mental patients, their families, local communities and, crucially, state governments, traditional bearers of responsibility for the custodial treatment of mental illness. At that point, the circumstances in which these actors operated made reducing reliance on state-run hospitals difficult; the prospect of significantly reducing state hospital inpatient populations thus also appeared unlikely. In the coming decades, those implications would be transformed — structurally and meaningfully. During the sixties, deinstitutionalization proceeded faster than even the most optimistic reformers of the forties had predicted. This was neither anticipated, nor widely

recognized at the time. One reason for this, I show, is that the acceleration had its origins *outside* of the field of mental health.

The rapid “success” of deinstitutionalization had complex causes. I focus on the contested part played by just one of them: the growth of the federal social welfare regime. Social welfare policies after World War II, of which the Great Society was emblematic, saw the federal government define a new, expanded role for itself in redistributing wealth on behalf of individual beneficiaries through existing markets. Enabled by this historic development, states during the 1960s and 1970s abdicated their role as custodians of the mentally ill.

The process that helped to drive changes in mental health resonates with historian Ira Katznelson’s subtle periodization of the US welfare state development: Post-World War II social policy was in one sense a continuation of the progressive redistribution first initiated on a large scale by the federal government in the 1930s. But in another important sense, it represented a departure: the blueprint for social inclusion in the Great Society programs left existing markets intact. Katznelson argues that this was a fundamentally conservative turn. By subventing the growth of market actors, the liberal social policies of the 1960s set in motion processes that “reinforced and exaggerated features of American politics,” which in turn conditioned the set of possible responses to what appeared in the 1970s as a crisis.

The crisis is well known, thanks to the familiar contours of those responses that have endured up through our contemporary moment: as growth slowed and spending outstripped

government revenues, the provision of social goods was ceded to the private sector. Political effort reoriented around attracting the favors of private capital. And the construction of new public responsibilities was off the agenda.

Deinstitutionalization came to represent a response to the crisis of the 1970s. Today it is often misremembered in light of the “neoliberal” solutions in social policy precipitated. In point of fact, it was largely executed before the crisis itself. If periodization were simple rather than complex, phenomena like reversals would not exist. Action would respect the frontier of social structural change, and come screeching to a halt at the line between historical regimes.

The transformed implications of psychiatric deinstitutionalization took years to materialize, and would not have been clear all at once. For a while at least, they were not irreversible. The challenge, then, for understanding the activity of historical actors involved becomes reconstructing what was apparent, when, and for how long. We can’t pose these questions as they appear to us now. The challenge for making sense of collective action is to reconstruct the publicly visible context in which its course was charted.

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A big part of this dissertation concerns automated text analysis. It plays an important role in the empirical project, allowing me to uncover the unfolding context for deinstitutionalization, and thus the significance of the mental health movement’s possible responses, as they

appeared to contemporaries. Doing this depends specifically on a method of selecting a set of documents that continuously represent a relevant part of the world. A collaboration with Jean-Philippe Cointet was the reason that the development of such a method was possible. That collaboration, itself spanning a long time period, was the context in which a lot of the other ideas in the dissertation came together, too.

Drawing together the case and the method, conceptually, is the idea of standpoint—a framework within which objects are ascribed significance. It is the ability to see social activity as continuous through time that allows us to conceive of social movements—or indeed, states, firms, or any other group-level social formation— at all. The ability to see *actors* in the events of the past thus presumes that we can see such events from a continuous standpoint. And equally, to see actors is to ascribe standpoints, in our accounts of past events.

Of late machine learning techniques developed in other fields have been widely adopted in the humanities and social sciences. Computational social scientists have often tended to regard these new methods in the way computer scientists talk about them: as “extracting meaning” from text—as though meaning were an inherent property, rather than a quality whose ascription varies in socially patterned ways. In this paradigm, automated text processing techniques offer a substitute for reading, available at lower marginal cost (Grimmer and Stewart 2013).



I wish to advance an alternative view: that such techniques are valuable precisely in that they are *not* like reading. Automated text analysis can help us craft what Clifford Geertz calls actor-oriented descriptions. It can help us to see the world as it appeared to others—from other standpoints.

The descriptions generated by abstracting texts computationally are at best close, but not deep. Compared with the novelistic access to others' worlds provided by those of Geertz and others, why would we want them? Not to replicate the work of ethnographers at poorer resolution, but because they allow us to capture what could never be observed by a single individual. In this respect, automated text analysis promises to open new empirical possibilities to social scientists.

The dissertation attempts to validate this methodological argument by example. Here, text analysis enables the study of action that unfolds over the historic *longue durée*. The formal continuity of language—in this specific case, of *The New York Times* coverage—makes it possible to select documents that represent distinct, consistent standpoints on a given part of the social world—that occupied by the state mental hospital—as it appeared to contemporaries over many decades. By abstracting these document collections, we achieve three forms of historical (i.e. diachronic) description. These descriptions allow us to identify changes in the social world as they could have been perceived historically. Like other actor-oriented descriptions, they do so insofar as they provide us a basis for achieving distance on our own rich, multifarious, and fundamentally invisible standpoints—the ones from which

continuity and change are otherwise inevitably seen.

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The dissertation proceeds as follows.

In the first chapter, I lay out the chronology of deinstitutionalization. I explain the sense in which the movement's history constituted what I call a reversal. When the aim of reducing reliance on public hospitals was defined, few recognized alternatives to the custodial state hospital were economically viable. Thanks to developments far outside the sphere of mental health policy, states abdicated their traditional role with respect to the mentally ill, while private markets in the management of specific facets of mental illness, and tranches of the former state hospital population grew.

But did they fall or were they pushed? In the second chapter I revisit a long-untouched debate over the mechanisms by which federal welfare policies shaped the state role in reducing inpatient populations in public mental hospitals. I replicate William Gronfein's state-level analysis of inpatient declines, and show that in fact, there is little basis for his claim that states relied on Medicaid to "dump" mental patients. In fact, patterns in trajectories of net discharge offer little evidence that deinstitutionalization was primarily a fiscal strategy on the part of state governments. The evidence is equally compatible with an alternative possibility: that

states released their patients—faced with growing demands that they do so—as an expanding healthcare marketplace absorbed them.

A movement on behalf of the mentally ill eventually discovered the market as its context. But it discovered it too late. By the time that a self-conscious mental health “consumer” movement emerged in the 1980s, it would have been extremely hard to make action on behalf of that group effective. With respect to the healthcare marketplace of the 1980s, the mentally ill were disadvantaged as individuals, differently positioned, and relatively enfeebled as collective actors. Could things have been different?

To address this question, it is necessary to define the historical window over which it is relevant. In the third chapter I present the document selection strategy developed with Cointet. The fourth, brief chapter proposes a way of assessing how well a given set of documents identified on this method capture a part of the social world as it appeared to contemporaries— a standpoint defined, necessarily, by the researcher herself.

I am then able to return, in the fifth chapter, to answer the question of movement periodization or casing. Starting with the domain relevant to the mental hospital in the period 1945-50, I compile three collections of documents, each capturing a distinct standpoint on this context over time. Analysis of these collections enables me to date the closure of key opportunities for the deinstitutionalization movement.

During the early 1970s a public target around which the movement on behalf of the mentally ill could have effectively organized itself disappeared: mental health vanished, in public view, from the field of general medicine. So we return, in the concluding chapter, to the actually existing movement organizations, their strengths, identities and their positions, the day before the movement failed to become a different one. It is a very rough sketch, but I hope it reveals the project's intention.

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I wrote most of the dissertation at home, listening to the faint, even screaming of an adult person from next door. My block is the site of what must be one of very few group care homes remaining in Manhattan in 2017. The screams were audible in the quiet mid-afternoon hours on most days; they accompanied me through the dissertation, and I occasionally wondered about their significance: for instance, were they bad or good? In closing, I wish simply to acknowledge the existence of a standpoint that does not receive much consideration in the dissertation: that of the severely mentally ill as individuals. Many different voices, over a relatively long period of history, are quoted here, but theirs are absent.

## CHAPTER ONE: DEINSTITUTIONALIZATION AS REVERSAL

*The republican bourgeois [opposition] faction which had long regarded itself as the legitimate heir of the July Monarchy, thus found its fondest hopes exceeded; it attained power, however, not as it had dreamed under Louis Philippe, through a liberal revolt of the bourgeoisie against the throne, but through a rising of the proletariat against capital, a rising laid low with grapeshot. What it had conceived to be a most revolutionary event turned out in reality to be the most counterrevolutionary.*

(Marx, *Eighteenth Brumaire*)

To take the poetry out of the most famous lines of the *The Eighteenth Brumaire*: social life is a drama of projects not working out. The actors in the drama are collective ones. But their failures are not a function of imperfect information per se, limited capacity, or organizational dysfunction-- the things sociologists worry about on such actors' behalf. They have bigger problems. For example, they don't know who they are. They bide their historical time, watching what others do, thinking up different lines, waiting for a cue that might be theirs. They confidently move forward—and are proven wrong.

The Chapter examines a mechanism that I call reversal: the transformation of an action's significance while it is underway, by rearrangements elsewhere in the social order.

There are two features of the of the world that make reversals possible. One is a well-established aspect of the sociological universe: the nesting and independence of domains of

social life. The idea is that actors, be they individuals, organizations, firms or states are embedded in more than one interactive landscape at a time.

The second feature is borrowed from historians: it is the retrospective standpoint. The penetration and the power of *The Eighteenth Brumaire* has everything to do with the fact that the author knows how things turn out. This allows Marx to illuminate what we might call dramatic ironies: the contradictions between the roles claimed at a given moment, and the ones his actors find themselves stuck with, as it were, at the end of the day.

The case through which I hope to explore reversal is psychiatric deinstitutionalization. The phrase refers to the dismantling of the mental hospital system, and the depopulation of mental institutions, which occurred in the United State between the 1950s and the early 1980s.

## **INTRODUCTION**

During the middle of the twentieth century, a reformers claiming to speak on behalf of the mentally ill called for transformations in US mental health policy. Its supporters rallied around a critique of the custodial mental hospital; they argued that American society needed to reduce its reliance on such institutions. Over the coming decades the movement born of their efforts succeeded in accomplishing this goal—to a greater degree and at a faster rate than even its most idealistic protagonists anticipated. The number of Americans confined in mental

institutions fell from 634,000 at its peak in 1955, to around 110,000 three decades later. And yet by the 1980s— even as the depopulation of state hospitals continued— the ambitious reform project had, by consensus, failed.

“The policy that led to the release of most of the nation’s mentally ill patients from the hospitals to the community is now widely regarded as a failure,” read a *New York Times* lede in 1984. The article goes on to recount what has become a familiar narrative: Rather than becoming “integrated into the community” upon release from custodial institutions, the severely mentally ill wound up isolated and without adequate resources— many of them, observers remarked, homeless—much less effective treatment (Frank and Gleid 2006; Torrey 2014; McAlpine and Mechanic 1990; Mechanic and Rochefort 1992, among others). Today’s assessments of psychiatric deinstitutionalization sound much like those of the mid-1980s: evaluations of the institutions that reformers once targeted differ, but commentators across the political spectrum agree that the social response to mental illness that followed was inadequate, particularly for the mentally ill themselves (consider the debate in *The New York Times*, in 2015). The policy of deinstitutionalization is characterized as representing a public “abandonment” of this group (for example: Gruenberg and Archer, 1979; New York Times, 1996).

Deinstitutionalization became an embarrassment to some of its earliest protagonists, many of them still living. In the same 1984 *Times* article, a number of noted psychiatrists are quoted

expressing regret for their role in this process. “It happened much quicker than we foresaw,” Bertram Brown of the National Institutes of Mental Health (NIMH) comments — but continues, with the rest of his colleagues to assume culpability for the failure of deinstitutionalization in a tone of regret, “[We] did not believe that community care would cure schizophrenia. We [let] ourselves be misrepresented.” These first person accounts however distort history, and they are also distorted by it.

In this Chapter, I develop the argument that deinstitutionalization constituted an historical reversal: an action transformed while it was underway by rearrangements in another part of the social order. Whether regarded as a success or a failure, the rapidity with which deinstitutionalization was accomplished could hardly have been anticipated. Nothing in the world in which it was conceived made it imaginable.

Chapter One proceeds as follows: I reconstruct the history of psychiatric deinstitutionalization in the United States in greater detail, laying out the chronology of the process from the standpoint of national policy. I then sketch a picture of the country’s public mental hospital system, as it existed at midcentury. The state mental hospital was deeply imbricated with key contemporary institutions: the justice system, the medical profession, hundreds of local economies. How could such an institution be “eclipsed” so quickly (Dowdall, 1996), leaving the vast population it had once confined, their vocal advocates recently so numerous, abandoned? I survey the different divers that scholars have proposed to account for the rapid



accomplishment of this transformation. Though the causes of deinstitutionalization were no doubt complex in fact, one of these explanations sticks out—a loose thread. Pulling at it unravels deinstitutionalization’s reversal.

The explanation in question focuses on federal welfare state expansion, and the thread is the traditional role of the states as custodians of the mentally ill. During the 1960s and 1970s, states governments were not only pressured to release their state hospital patients—by mental health advocates, lawmakers, new professional groups and the infungible weight of “public opinion”—they were newly incentivized to do so: States gradually relinquished the custodial role they once played, releasing patients from mental hospitals as the federal government assumed many of their former fiscal responsibilities. It did so through an expanded set of redistributive programs not specifically targeted at the mentally ill, but which subvented the fulfillment of their basic needs, such as housing and medical care, through the private sector. Only as federal policy shifted in turn in the late 1970s, and spending through these programs was rapidly curtailed, did the abdication of public responsibility for the mentally ill as a group reveal itself.

Both the transformed fiscal relationship between states and the federal government in the realm of social welfare, and the subsequent retrenchment in federal policy transformed the mandate to reduce reliance on mental hospitals. Both developments contributed to deinstitutionalization’s reversal. I conclude by explaining the idea of historic reversal more

abstractly, I briefly point to several other cases of reversal, and distinguish them from episodes that are not reversals.

## **NATIONAL MENTAL HEALTH POLICY: A CHRONOLOGY**

At the close of the second World War, the role of state-run institutions as custodians of the mentally ill in the US was practically unquestioned. Mental asylums had emerged in the nineteenth century as progressive alternatives to almshouses, and were initially financed by philanthropists, with occasional public support (Gorb, 1973; Lerman, 1982; Katz, 1996). Private mental institutions continued to exist into the next century, some cities and counties also operated them, but in the twentieth century most US mental hospitals were run by states. A succession of theories of mental disease and treatment ideologies underwrote the existence of the mental institution, some placing more weight than others on its therapeutic role (see Rothman, 1990; Grob, 1973; 1983; 2014). By the early twentieth century, a disease model of mental illness qua psychosis sat side by side with the psychoanalytic approach to neurosis. Psychiatry's construction as branch of medicine and Freudian theory thus mutually supported the institutionalization of psychotics as a population requiring specialized treatment (Grob; 1983) in theory. In practice it appears that for most of their history America's public mental hospitals

Theoretical changes in psychiatry in the 1920s and thirties refocused professional attention on the environmental sources of mental illness, a perspective consecrated by American psychiatrists' military experience during WWII (Grob, 2014). A generation of younger psychiatrists who came to prominence professionally after the war did so with a view of mental disturbance as having contextual sources, hence treatable through the manipulation of social context. Their conflicts with an older branch of the profession played out within the American Psychiatric Association, often as debates over the theoretical or evidentiary foundations of therapeutic practices deployed within mental institutions. During the late 1940s these intra-professional conflicts spawned the Group for the Advancement of Psychiatry, and other professional organizations through which psychiatrists would help to mobilize in favor of for the federal reform of mental health policy (Grob, 2014).

The end of WWII saw calls to reform state hospitals, which were physically degraded and overpopulated during the war. A number of journalistic exposés during the forties brought attention to the poor conditions within state mental hospitals. One key source of lay attention came from conscientious objectors, who had been sent to work as attendants in these overtaxed and understaffed institutions in lieu of military service (Sareyan, 1994; Taylor, 2009). They founded membership-based advocacy organization devoted to mental hospital reform. Organizations on this model, the lost province of Robert Putnam, grew quickly during the postwar period; they were a fixture of state-level mental health politics into the sixties (see

for example Bardach, 1972). Over the course of the fifties, donations to such organizations doubled (Kadushin, 1969).

It is important to note that during the 1940s neither mental institutions' critics in psychiatry or in the media suggested that these institutions should be abolished. Their problems themselves, however, were more and more widely acknowledged. In 1946 Congress funded the National Institute of Mental Health (NIMH). By 1949 the Conference of Governors began holding special gatherings on the problems of state mental hospitals (Council of State Governments, 1950). State efforts appear to have focused during this time on the severe "manpower problems" faced by mental hospitals, a recurrent theme throughout the institution's history. Regional efforts were undertaken to address this, for example, through university programs to train more professionals (US Senate, 1955).

The 1950s saw the consolidation of the field of psychiatry academically, around psychodynamic theories of mental illness—and also its consolidation as an actor in mental health policy. A variety of organizations advocating for mental institutions' reform also merged organizationally in the 1950s, reflecting an attempt by the professional elements of the movement to absorb and channel the energies of lay reformers (Gorb, 1991; 2014). It seems that the fifties were the historical moment when the prospect of a national policy on mental health first began to appear serious.

Hearings on the troubles reform of state mental health systems were held in 1955 in both the House and the Senate (US Senate, 1955). Though “largely symbolic,” according to historian of mental health Gerald Grob, they effectively publicized the idea that preventive treatment could significantly reduce the population of mental institutions. The hearings also highlighted the promise of recently synthesized antipsychotic drugs. In their wake, Congress funded a report by a committee of mental health professionals that was to propose recommendations for a comprehensive national mental health program.

Following John F. Kennedy’s victory in the presidential election of 1960, mental health advocates mobilized rapidly to influence national policy. In 1961, a coalition including the APA, the Association of American Psychologists, the Governors’ Conference, and the national membership-organization for mental health reform fell into line behind a set of policy recommendations based on the Joint Council report, which it issued to the new presidential administration.

The coalition of reformers found a receptive audience. In 1963, Kennedy issued a special message to Congress, making a humanitarian appeal for a “bold new approach” to the care of the mentally ill and disabled. The President claimed that under the guidance of a federal policy focused around “community mental health centers,” the population of the state mental hospitals could be reduced by 50% “within a decade or two.” Community Mental Health Centers Act passed the same year, and authorized federal matching grants to the states for new

construction. The legislation marked the “beginning of a new era in Federal support for mental health services,” according to NIMH historians. In 1965 the Johnson administration made funding provisions for CMHC’s staffing, on a limited-time basis.

As the “new era” in federal involvement in mental health policy opened, the sixties saw a broadening cultural interest in the mental hospital, and ever more vocal concern for those committed such institutions. Goffman’s *Asylums* was published in 1962, the same year as the publication of Ken Kesey’s *One Flew Over the Cuckoos Nest*, and a year after Foucault’s *Histoire de la Folie* first appeared in English. Even before the passage of national legislation, the idea of community mental health had traction with a great variety of locally-based groups and activist organizations. Community mental health programs were in fact already operative in a number of states (Weddle, 1998). With the introduction of federal funding for the Centers, many more groups devoted broadly-speaking to community development appeared, unsurprisingly, oriented to mental health (Kellam and Schiff, 1966; Harris, 1966).

During the later part of the 1960s the radical movement within psychiatry grew, and issued calls for alternative treatment modalities — preeminently group therapy. Radical psychiatrists were sometimes allies of a group that was growing during this period: former inmates of mental institutions. Mostly based in cities, a loose network of former mental patients groups grew. Some evidence suggests that these groups of ex-patients were the primary contacts and resources for organizing among the mentally ill still resident in state hospitals. The movement

for mental patients during this period was influenced by other social movements of the period, primarily the women's and black liberation movements. The affinity was manifest in the discourse and consciousness-raising practices adopted by ex-inmates' groups, where participants' shared history was formulated in terms of a unique form of social oppression, misrepresented individual pathology.

Over the course of the 1970s a number of high profile court cases were litigated on behalf of the mentally ill. They are characterized by lawyers and mental health professionals as having resulted in the recognition of three rights: (1) the right to treatment in the "least restrictive" environment, (2) the right to refuse treatment, and (3) Freedom from confinement. These cases both advanced the deinstitutionalization agenda in law, but also generated visibility and further public support for mental patients. The experience of the NYCLU Civil Liberties and Mental Illness Project and the Mental Health Law Project, the individuals who became leaders in the legal arena had little personal or professional experience with mental institutions or mental illness.

The psychiatric profession — major element of the successful organizing around mental health policy at the national level during the 1950s and 1960s— nearly disappears as force in activism on behalf of the mentally ill and in mental health policy by the middle of the 1970s. Psychiatrists played a diminishing role in running Community Mental Health Centers. Some suggest that this was because of their increasingly orientation to social welfare clients more

generally-- ie a loss of specifically psychiatric focus (Winslow 1979). By all accounts, the CMHC's defined for themselves diverse missions during the late sixties and seventies (Torrey 2015; Kadushin 1969; ETC). In 1970 they assumed a blanket mandate from Congress to provide drug and alcohol abuse treatment. Bracketing characterizations made in retrospective accounts of the CMHCs' role in the failure of the period's mental health policy (eg Torrey 2014): the NIMH during this period does not make it easy to know what the Centers it funded were doing. For this reason, it seems, the federal agency became the target of an investigation spearheaded by Ralph Nader. It is notable that while the Nader report is highly critical of the NIMH; its authors also find the project of reducing reliance on mental hospitals so self evidently virtuous, that the case for it does not need to be argued (Chu and Trotter, 1974).

Deinstitutionalization appears to have been discovered during the late 1970s. At that point a number of reports issued forth from the federal government on the country's mental patients (Government Accounting Office, 1977; National Institutes of Mental Health, 1977); they will be discussed in greater detail below. In the same year, the new Carter administration initiated a presidential Commission to report on the state of the mental health system nationally. Two years of consultations ensued (Grob 1995). The result was the passage of a Mental Health Systems Act of 1979, which affirmed the national commitment to "community-based care," and sought to improve it.



The MHSA did not have time to take effect. The following year, Reagan's Omnibus Budget Reconciliation Act reversed the provisions of both the original Community Mental Health Centers Act of 1963 and the Mental Health Systems Act of the previous year. More significantly still, it devolved responsibility for mental health entirely to the states, parceling out a portion of the remaining funding allocated to CMHCs in the form of block grants. According to Grob, "the new legislation did more than reduce federal funding for mental health," ... "It reversed nearly three decades of federal involvement and leadership. In the ensuing decade the focus of policy and funding shifted back to the states and the local communities, thus restoring in part the tradition that had prevailed until WWII" (Gorb, 1995).

By 1984, mental health policy of the past three decades was "widely recognized" as a failure, at least in the view of *The New York Times*. In the same year, The American Psychiatric Association published a repudiation of and apology for deinstitutionalization. Even as its failure was being trumpeted in the media, deinstitutionalization continued. In 1987 The National Institutes of Mental Health officially deinstitutionalized itself, ceding administrative control of its one time research-base, St. Elizabeth's Hospital, to the District of Columbia.

## **THE MENTAL HOSPITAL AT MIDCENTURY**

Of the 634,000 Americans in mental hospitals in 1955; about 559,000 were in public institutions. Some estimates would put the total figure a little higher, but it The majority of these were run by states governments, although about five states had county-run mental hospital systems. This meant that in 1955, the significant majority of Americans in state custody were in mental hospitals (Kramer, 1977). Rates of institutionalization all state-run institutions in the US in 1955, were thus comparable to those in the early 2000s.

Most people in public mental institutions, for most of the institution's history, could not legally leave. Until the 1960s the most common circumstance of admission was involuntary commitment (Weinstein and Maiwald 1974); which in 1939 accounted for 90% of all admissions nationally (National Institute of Mental Health, 1974). It is worth appreciating what a focus on national civil rights victories of the mentally ill in deinstitutionalization largely leave out: Reducing reliance on state mental hospitals meant disassembling the complex state legal codes underwriting involuntary commitment. In New York and California, major reforms occurred during the mid-1960s (Bardach 1972; Gupta 1971).

Grannie notes that administrative procedures for commitment and discharge were deeply embedded in "the public safety functions of the state mental hospital." (1985: 194) As a consequence of both, observers of the late 1960s remark that, "involuntary commitments constrain the hospital as well as the patient," (Greenley and Kirk, Rock et al 1968). Lack of

control over admissions is a recurrent theme in the writing of and about mental hospital superintendents.

Mental hospitals of the mid twentieth century were as large as they had ever in the institution's history been. In the writing of the Joint Commission on Mental Illness there is a fixation with the number 1000, as the upper limit on the desirable number of beds (*Joint Commission*, 1959). The number of public hospitals in the country would have put the *average* at about 1700 beds in 1955. Mental institutions were underwritten by a variety of administrative structures at the state level (Grob, 1983; Lowry, 1953). There is some contemporary discussion about whether patients or their families should have to finance the costs of their care in states hospitals (Mernitz, 1961). But this seems to have been largely philosophical; even those engaged in it acknowledged that, "in practice less than 10% of the costs of care in most state mental hospital systems are recuperated through private contributions," (Mernitz, 1961). States mental hospitals' operating budgets did not depend on such revenues; they were line items in the budgets delivered to states legislatures, and at least in the fifties, invariably approved (Mernitz, 1961; Bardach, 1972).

The large states mental hospital of midcentury were major employers, not just of medical staff but of cooks, groundskeepers, technicians of all kinds, in addition to (never enough) unskilled attendants. In 1955 the majority of states Mental Health Authorities were spending over half of their budgets on staff; they saw secular increases of this proportion after the war (NIMH

Mental Institutions Census). Thus budgets of public mental institutions, practically speaking, were affected on one hand by variables they could not control, namely the rate of admissions and available staff, and on the other by things that they could, like how much their farms were able to produce. Before deinstitutionalization most relied to some significant extent on patient peonage.

So who were these institutions oriented around treating? The Census of Mental Institutions conducted by the PHS and subsequently the NIMH provides a picture of the mental hospital population of the country as a whole, but it is thus representative of no particular state. Our best answer probably comes from Hollingshead and Redlich's famous 1958 community study of psychiatric treatment for mental illness. They studied a population receiving psychiatric treatment New Haven, Connecticut, which they categorized by social class. Their population is hardly representative of the US -- there are not enough blacks in the study to draw many conclusions about race, for instance; but the conclusions they do draw are broadly coherent with those drawn by other contemporary studies, including those they do and do not cite (see for the latter Hardt and Feinhandler 1959). Importantly, for psychiatric patients in New Haven in the late 1950s, nearly all known treatment modalities for mental disorder were locally available: some saw private practitioners, others visited public clinics, some were in Veterans Authority hospitals—and the majority of all episodes of mental illness, around 66%, were treated in the state mental hospital.

Hollingshead and Redlich find first, that treatment for mental illness was strongly patterned by class. The mentally ill receiving treatment were disproportionately of their lowest class, “V”. These same patients were also most likely to wind up in treatment through encounters with the law or other public authorities, as opposed to their families. Diagnoses were also class patterned; the upper classes disproportionately receiving diagnoses for milder “neurotic” disorders, lower class people were more frequently diagnosed with psychosis— patterns which held irrespective of sex and age.

Second: the modality of treatment of mental illness was also strongly patterned by class. However, among the patients in the study diagnosed as psychotic -- the majority of all those receiving treatment -- differences were much attenuated: even their class I-II patients are split nearly evenly between treatment in private and state hospitals (1958, p. 280-282).

Hollingshead and Redlich are straightforward in suggesting a mechanism to account for the latter pattern: psychotic patients see continual treatment (p. 280)— which exhausts the resources of some households faster than others (p. 281). The impact of this dynamic “is seen dramatically” in the middle class patients, “from 83 percent to 100 percent of each diagnostic group originally treated in private hospitals shifted into other agencies in their current treatment” -- ie the public hospitals, Veterans and state (1958, p. 281). Hollingshead and Redlich show that attitudes to treatment in general are patterned by class too (chapter 11) — but their attempts to make sense of their findings seems to have largely taken for granted that

*all* classes in their study tried, on their own behalves and on behalf of their family members, to avoid the state hospital. The lower class in the study expressed hate and fear of these institutions, the only psychiatric treatment relevant to them, openly; the upper and middle classes did their best, not always enough, to keep their family members out of them.

It is thus noteworthy that Hollingshead and Redlich ended their study with a surprisingly open-ended discussion of the costs of mental hospital care: “In spite of the importance of the problem there is little known about the economic burden of mental illness,” they write, “on the population as a whole, or to individuals and families. Moreover, no systematic studies have been made to determine the connection between class status and expenditures on treatment of the mentally ill.” (1958: 304).

## **PROPOSED DRIVERS**

“Rare, indeed, is it in social policymaking for measured accomplishments to outdistance stated goals,” as sociologists of mental health David Mechanic and David Rochefort observe (1992, p. 302). Like Mechanic and Rochefort, most analysts of deinstitutionalization agree that “many influences were operative, including changing ideas and attitudes about the nature of mental illness and its treatment, biomedical advances, social research, professional currents, legal activism, and the emergence of a powerful political coalition in support of the mental health reform movement” (p. 303).

Still the chronology of deinstitutionalization is curious. Specifically puzzling is the rapidity of the institutional transformation, over a mere few decades. Also puzzling are the contrasts in the public reassessment of the policy—which appears to have occurred over few years during the late 1970s to the mid 1980s. Below I survey the different drivers that have been suggested—or that might suggest themselves—to account for deinstitutionalization’s rapid accomplishment. I weigh the evidence for the plausibility of each.

Whatever else was responsible for the transfer of populations out of mental hospitals, it was not the closure of the facilities themselves. In the 1980s there were about the same number of operational state mental hospitals in the US as there were at the moment at which the resident population peaked in 1955 (Gorb 1991, ch 9; 1995). Dowdall’s study carefully demonstrates how state mental hospitals were eclipsed as institutions, without being systematically shut down (1996).

Change in the cultural understanding of mental illness has sometimes been offered to account for the transformation of the mental hospital system. So, more specifically, has acceptance of the idea that severe mental illness could be treated outside of specialized psychiatric institutions, for example in general hospitals (Ewalt 1979). This probably made a difference. Here are excerpts from three case studies, published in 1959 in the *Journal of the American Medical Association*. The authors are trying to make the case for the feasibility of general hospital treatment:

*The patient was a 40-year-old man, a member of the faculty at a local college, who was seen for four months in outpatient psychotherapy because of a depression [...] Despite psychotherapy and the use of drugs, he became psychotically depressed. [...] After additional study in the hospital, electroshock was prescribed and started. [...] the depression began to lift but the patient was realistically concerned lest a long hospitalization be detrimental to his career. When it was clear he was no longer a suicidal risk, he was permitted to leave the ward for a few hours a day to work. He traveled to his campus where he prepared and delivered lectures, met with his colleagues, and began to write papers again, while still receiving electroshock. The treatment in the hospital continued until the patient's depression lifted.*

*The patient was a 36-year-old married composer, who [...] had had several episodes during which she wandered aimlessly, apparently out of contact with reality. [...] Psychotic signs—disorientation to time, delusions of electricity coming out of the ceiling, fears she had killed her husband, speech retardation and blocking, distractibility, and poor concentration—were present. [...] As intensive psychotherapy brought into focus the patient's problems with her husband, he was encouraged to visit her and began bringing his lunch on the ward to eat with her. [...] After two weeks of hospitalization, she began visiting at home for increasing periods of time. By the time she was discharged, none of the signs of gross emotional disorder remained.*

*The patient was a 50-year-old schoolteacher who was admitted to the psychiatric service as a transfer from neurosurgery two months after receiving a severe cerebral contusion by throwing herself in front of a truck. This suicide attempt occurred after a year of great emotional strain after separation from her husband to whom she had been married for many years. [...] Her husband was asked to visit with her several times a week; his determination to get a divorce became evident. The two were able to talk freely about this, the patient's attempts to deny his desire for a divorce crumbled but did not increase her depression, since she was guided through this trying period by psychotherapy and by the support of all the personnel and other patients. This permitted her to see this problem more clearly and for the first time begin to plan her future more realistically. Her lawyer spent time with her on the ward, helping her work out details in a straightforward manner rather than the confused approach habitual to her in past years. A conference with school authorities permitted planning whereby the patient was, after discharge, to teach half-time and go to school half-time to work for an advanced degree.*



(from Tidd et al., 1959)

These patients, with their careers to worry about, their lawyers, and their husbands free to come by for lunch, are clearly not a representative sample of the state hospital population that Hollingshead and Redlich described. The authors' intentions notwithstanding, it is also not clear how these treatments work out for them over the long term. But it is worth considering that in 1959, not only was the thought of treating serious mental illness outside of psychiatric institutions was novel enough to make this article worth publishing in a major medical journal, but the vast majority of commitments to mental institutions were still legally involuntary. Much later, disability policy under the Carter administration would guarantee the benefits of individuals who voluntarily declared themselves able to work—a promise of security designed to encourage people to “walk off the rolls.” In the case of state mental hospital care, it is likely that once alternative options became available and acceptable, those who could afford to avoid the state hospital, did so. Many indeed probably “walked off.”

The invention of antipsychotic drugs is a very commonly cited driver of deinstitutionalization (Starr, 1982; see also Gronfein, 1985b). Chlorpromazine was first marketed in 1954 — chiefly, to states mental health authorities—with immediate success. It and other psychotropics are often described as making the behavior of patients “more predictable,” hence easier to manage for nonprofessionals. In contrast to other contemporary forms of psychiatric treatment like electroshock therapy, hydrotherapy and insulin shock,

antipsychotics could be administered anywhere. Other arguments that focus on these drugs' role in accelerating deinstitutionalization assert that their initial reception (or marketing) crystallized the belief that they would enable mental patients to function outside an institutional environment.

In fact, as an explanation of declining rates of mental hospitalization, the role of new drugs was already being contested as it gained popularity. In the early 1960s, mental hospital administrators felt the need to point out that in states where their peers had made ambitious efforts to use new drugs to "return patients to the community,"— New York being the best known contemporary example—states mental hospital systems saw their admissions rates increase again within a few years (Bower and Wignall, 1965; Brill and Patton, 1959; 1962). They pointed out that without fundamental changes in the practices of staff and administrative operations of state hospitals, drugs themselves were of little to no relevance (Bower and Wignall, 1965).

Indeed, Brill and Patton, the New York State psychiatrists who had first published on their experiments with drug therapy in 1957, soon felt they had to clarify. By 1962, the two sought to qualify the conclusions that had been widely drawn on the basis of their original *suggestions* —they now emphasized—about the link to the state's net inpatient declines (Brill and Patton, 1962). First, the evidence as to drugs' part in the declines "remain[ed] no less open than it was in May 1957" (1962, p. 20). Second, if even if drug therapy had played a

role, the authors cautioned, its overall effects on state hospital populations should be expected to be limited. Drugs were effective only for some patients, and in those cases more for “reducing active positive symptoms than in controlling negative ones, such as occupational inertia, vocational incapacity.” (1962: 25) Further, for patients to avoid rehospitalization, “drugs [might] have to be maintained indefinitely” after discharge—something that New York state psychiatrists of 1962 evidently viewed as impractical (Brill and Patton 1962; 24).

Analyzing declines in the Department of Mental Hygiene’s mental hospital populations — concentrated among the very young, the majority of lasting releases, and the very old — Brill and Patton put the likely reduction in the state mental hospital population at somewhere between 6% and 19%.

National trends in mental hospitals’ resident populations between the 1950s and the 80s indeed make it appear unlikely that the drugs, so widely adopted during that period were the crucial driver. The total resident population of state hospitals declined gradually from 1955-1965—from 559,000-475,000, a reduction of somewhat under 20 percent—but it began to decrease more precipitously in 1965. The period of 1965-75 saw a drop of about another 60% of the 1955 total. After 1975 the rate of the decrease tempered.

Net decreases in rates of residency at state mental hospitals 1975-1985 were comparable to those 1955-1965. The decrease in discharge rates during this latter period helps to qualify another claim with causal flavor: that success at changing the legal regime governing

psychiatric commitment drove deinstitutionalization. The success of class actions like *Wyatt v. Stickney* (1971) and *Wyatt v. Alderholt* (1974) recognized the “to treatment,” *Rogers v. Okin* (1975) found that committed mental patients had the right to *refuse* treatment; *O’Connor v. Donaldson* (1975) ruled that individuals could not be committed to mental institutions without their consent. But the earliest point by which the effects of these judicial rulings could have been discernible was the late 1970s Grob argues (1991), by which point the rates of net discharge were leveling off.

A more recent body of work has probed the relationship between institutionalization in psychiatric hospitals and in jails and prisons (Harcourt, 2006, 2007, 2011, 2014; Earley, 2006; Torrey, 2014; Raphael and Stoll, 2008; Prins, 2011). The dramatic reduction in rates of confinement in mental hospitals occurred coterminous with a well-known increase in the rates of incarceration in the US. This particular “transinstitutionalization” hypothesis has not had a clear conceptual articulation. The evidence challenges many of its possible formulations however: those institutionalized through the mental health and criminal justice systems fail to resemble one another demographically or clinically (Prins, 2011; Frank and Glied, 2006). Bernard Harcourt does offer a general theoretical argument for the relationship between deinstitutionalization and the prison boom, namely, that the two institutions are functionally equivalent, both responding to social deviance (2006, 2007). However Raphael and Stoll’s analysis has shown that not until the 1980s does any relationship appear between prison and mental hospital populations at the state level (2008). On the whole, there’s little about the

*subsequent* rise of mass incarceration to explain the by which deinstitutionalization occurred, or account to account for its rapidity.

What about the Community Mental Health Centers of the 1963 legislation? During the latter part of the 1970s the national CMHC policy was widely, if casually, understood as the source of any changes observed--or not observed quickly enough--in the mental health treatment system in the US (Smith and Hanham, 1977; Chu and Trotter, 1974). communication between state mental hospitals and Community Mental Health Centers was never widely institutionalized. Hence, according to a GAO report of 1974, "Public mental hospitals accounted for fewer referrals for CMHCs than any other referral source reported, except for the clergy" (cited in Lerman, 1982). It is also worth noting the appropriations for staffing, \$260 million over 1965-1969. The funding channeled through the new national mental health policy, seems rather slight compared to other programs of the period. For example the Medicaid program, in 1966, the the first year of its existence, resulted in a net increase of federal payments to medical vendors of nearly twice the entire amount (Prince and Cooper 1968: 9).

The most convincing single-driver explanation that has been offered for deinstitutionalization is probably the expansion of the federal welfare state. Such accounts link decline in mental hospitals' inpatient population rates nationally from mid-sixties to the mid-seventies points to a source of change *unrelated* to mental health policy: the growth of federal entitlement

programs. These accounts most often point to the significant wave of post-WWII welfare state expansion came in 1965, and which included Medicare and Medicaid. The latter program subsidized care in “skilled nursing facilities”, thus fostering the growth of the nursing home system, whose resident population nationwide nearly doubled during the sixties. Both programs allowed beneficiaries to claim reimbursement for care in general hospitals, including psychiatric services. In 1972, the federal government expanded income support the elderly and the disabled, and reorganize it under the Supplemental Security Income (SSI) (Berkowitz and DeWitt, 2013; Derthick, 2011).

With some exceptions, residents of mental hospitals could not claim these benefits, state custody made them either formally or practically ineligible. Provisions of these different programs and their particular implications for states varied widely, in ways that we will examine in greater detail in the next Chapter. But the key point made by authors who focus on the expansion of the federal welfare state as a driver of deinstitutionalization, is that these developments incentivized a change in state behavior with respect to the mentally ill—insofar as states claimed federal subsidy by moving the mentally ill, they relieved the the costs of their expensive mental hospital systems. That is, thanks to federal policies unrelated to mental health, these arguments go, the states role in their capacity as guardians of the mentally ill changed.

This argument is quite plausible. As we will see in some detail in the next Chapter, federal spending on the Great Society health programs far outstripped what it offered states to fund community mental health centers. In 1965, the Johnson administration also authorized staffing grants to the federally-sponsored CMHC's, completing the unfinished work on the Community Mental Health Act of the previous administration. But no relationship between the two policies was understood to exist at the time; Titles XIV and XIX of the Social Security Act Medicare and Medicaid, specifically excluded from their purview the states' traditional responsibility of funding their mental hospital programs. "It is important to emphasize that the federal government could not — and did not — mandate that categorical grant-in-aid programs be used to depopulate state institutions," Paul Lerman writes. "States had to discover and choose this discretionary option." (1982, p. 79)

In 1977 Medicaid alone was "one of the largest single purchasers of mental health care and the principal federal program funding the long-term care of the mentally disabled," according to the federal government (GAO report, 1977). Authors who make the argument about federal welfare expansion have also pointed out that the timing of deinstitutionalization varied from state to state (Lerman, 1982) -- suggesting that such variation reflects states' uneven "discovery" of their new discretionary option. With the exception of Gronfein (1985a), no study has attempted to show that this is the case. In fact as we will consider in the next Chapter, the historical pathways of deinstitutionalization across states does offer evidence of a general kind to support the welfare state thesis— though the timing tells us little absent a

more specific account of *how* state action would have been transformed by new fiscal incentives in the area of mental health.

It seems doubtful that any single-driver explanation of the process of deinstitutionalization is adequate. What is key about the claim — apparently unarguable — that federal welfare policy played a part in this process, is the light it shines on the role of the states with respect to the mentally ill.

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To summarize: Reforms in mental health policy were undertaken for the first time at the national level following WWII. The 1963 Community Mental Health Act was the central achievement of this reform effort; in it, the work of a mental health reform movement appears. It was the pursuit of a federal mandate for community-based mental health policy that brought together a coalition of mental health reformers during the 1950s. In the early 1960s they appeared to have accomplished their first goal. The coalition members continued their efforts at reform in other spheres—buoyed by the federal success.



Through the better part of the 1970s changes in the treatment of the mentally ill were attributed this national mental health policy of community care. The National Institutes of Mental Health continued to authorize grants for the construction and staffing Community Mental Health Centers. Equally during this time states reduced their rates of mental hospitalization.

In 1977 research published by the federal government made clear two things: First that national mental health policy had apparently worked, in the sense that states across the nation had significantly, indeed radically, reduced their mental hospital populations (Kramer, 1977; GAO, 1977). Second, it had not worked through the anticipated mechanisms. The discovery of the GAO was that were that with, the federal Community Mental Health Centers mandate of 1963 in place, states had relied heavily on *other* federal programs to reduce to release mental patients from state custodial care.

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It hard to imagine how so decisive and rapid a change in the way that states governments approached their traditional role with respect to the mentally ill could have occurred, unattended by overt conflict, absent all kinds of cultural encouragement and public support — that is, without the prior efforts of the movement: the reformers of 1950s, the symbolic force of Kennedy's appeal to Congress and the consensus it helped to shore up, the CMHC Law,

and a growing movement for reform that included more and more former mental hospital inmates.

On the other hand, it also seems clear that CMCH policy could not have been responsible for the change in states' behavior by itself, in the context in which it was achieved. The GAO's discovery that many former mental patients were living outside of state institutions, supported on Medicaid, is merely one indication of a transformation.

In fact, the Kennedy proposal was modeled significantly on the policy of New York State, which had instituted a system of community mental health clinics in the 1950s. (It is rumored that when Governor Nelson Rockefeller heard of the "Kennedy" community mental health plan, he exploded in outrage at the rip-off (Weddle, 1998).) Recall the predictions of the radical advocates of community care at the New York Department of Mental Hygiene during the early 1960s: for Brill and Patton, a 20% reduction in their own exemplary state's inpatient population over the next decade would have been too much to hope (1962, p. 21). All this suggests that it was indeed thanks to subsequent developments, outside of the sphere of mental health policy, that the significance of the 1963 federal mandate for states was transformed.

It bears clarifying, too, that there is no evidence that states governments themselves anticipated a changed role for themselves when national mental health policy was first

defined. During the high-level mobilization among mental health reformers that followed Kennedy's election, mental health lobbyist Mike Gorman appears to have had little trouble getting the Governors' Conference to back a set of recommendations based on the advocate-led Joint Commission on Mental Health and Illness. Five years previously, when the Committee was formed, not a single state representative sat on it, and no governors testified at the Congressional hearings on mental health policy. To Grob, these latter facts indicate that "states were not seeking a greater federal role merely to transfer their fiscal responsibilities" (2014). All in all, in the *formulation* of national-level mental health policy, the states appear to have acted as dead weight: they manifested little interest in the matter. There seem few strong reasons to suppose that without this direction already indicated to them, states governments during 1960s and early 1970s would—or could—have looked a social group whose special treatment they had struggled to manage for decades, and simply abdicated the responsibility.

## **DEINSTITUTIONALIZATION AS REVERSAL**

In advocating for the passage of national mental health policy favoring deinstitutionalization, reformers sought to assign a new role: in discharging the inmates of state mental hospitals, states governments were to become the promoters of enlightened non-institutional care. In making this move—we can reasonably imagine—mental health advocates applied theory about state governments as actors in the arena of mental health. That theory was not unreasonable, based on the past century or so of observed practice: States were the principal

bearers of both the social and fiscal responsibility for the mentally ill, bundled together in the institution of the state mental hospital. They were like highways, parks, or any other slice of the social world transformed through . Though they constantly overtaxed by more patients than they could serve, states had exhibited little interest in finding other ways of discharging this responsibility. Hence, advocates of deinstitutionalization might have reasoned, the way to encourage states to experiment with other modalities of care was to lower the costs of providing non-institutional options. This was what the CMHC Act was to do.

For a mental health movement around 1960, deinstitutionalization looked rational—and would have continued to do so had the context for action remained frozen in time. That is, if the actors then relevant in mental health were doomed to iterate, repeating only the behaviors they'd exhibited in the past decades, the effort to effect the 1963 legislation as step toward community-based treatment would not have seemed misguided.

Surveying the possible players in the field, this group of reformers identified the federal government as their best chance for leverage. This reflected a view of the federal government as comparatively more receptive to progressive reforms states that was typical of the time (Gorb, 2014; Torrey, 2013; also Swartz and Peck, 1990). And obviously federal law was, theoretically, capable of affecting uncoordinated policies of the forty-eight state mental health agencies.

In seeking to affect national policy, they did not misjudge what they were capable of. Nor were they wrong about the immediate consequences of their action, namely, the institution of a national mental health policy that favored the transfer of individuals out of public mental institutions. (If they had been wrong about either of these things, the outcome of deinstitutionalization would not have been the result of a reversal — but simply of shortsightedness, bad judgement.) The win that the deinstitutionalization movement achieved in 1963 was real enough.

Consider the implicit context of this quote, given by a state worker in a Wisconsin mental hospital, approximately one decade later: “They come in and look at the patient [...] and if they are too fat and look like they’re not easy to care for, they’ll reject them. If they’re going to take patients to try to rehabilitate them, as they claim, they should take a look at the medical record to see if they have the facilities and personnel.” (Ruth Brown, quoted in Satiestevan, 1975)

The “they” referred to here is *not* the Department of Welfare—the agency then responsible for operating mental hospitals in Wisconsin at the time—nor is it any other agent of the state. Rather, the behavior Brown is complaining about is that of representatives of a skilled nursing facility, on a periodic visit to the hospital to canvas for (presumably Medicaid-eligible) potential customers. Let us bracket, for a moment, the nursing homes themselves, and their dubious rehabilitative capacities, to which the speaker seeks to call attention. Let us focus

solely on the transformation of the state role. Here the public hospital is simply the backdrop, against which decisions about the fate of the severely mentally ill are transacted.

Over the course of the 1960s and 1970s states began to abdicate responsibility for the mentally ill, first as individuals—eventually, as a group. Federal policy had abetted this change, by reducing the relative costs of care outside of state hospitals. It would be fair to say that it played helped to transform the types of actors that states *were* in the area of mental health. By 1973 when Brown’s statement was made, states governments could forgo *all* of the costs of maintaining an individual in a mental institution, under SSI’s disability provisions.

If by reducing the cost of alternatives, federal welfare programs helped to transform the states’ role, it would also be fair to say that the *revealed* what the role had been in a new way. As an institution, the state mental hospital of midcentury combined a number functions, which it had traditionally discharged on behalf of inmates, whether they liked it or not. For one, the institution did a kind of work that could be described as social mediation—per the focus of contemporary critiques associated with Szasz, Laing, Goffman and others. It shielded society from those classified as mentally ill on one hand, and it conditioned the treatment of the mentally ill on the other, though it did so in the crudest conceivable way, through segregation and confinement. The crudeness and indeed the cruelty of involuntary confinement however, did not detract from the fact that mental hospitals had provided shelter, food, medical care and

domestic services -- in addition to in theory providing therapeutic treatment that was rarer in practice.

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But if the federal welfare state expansion helped transform the kinds of actor states were as providers of mental health, why should it have been alone? Indeed federal health programs were modeled on, and essentially erected on top of, an existing institution: medical insurance. It thus surprising that the growth of *that* system is not cited more frequently as a driver of deinstitutionalization (Ewalt, 1979). Prepaid employer-provided insurance plans for general hospital care emerged as a way to keep hospital solvent during the depression of the 1930s, and rapidly grew in popularity. Later insurance for mental health care specifically developed. Chu and Trotter remark from the vantage of 1974, that “as late as the mid-sixties employers preferred to keep their heads in the sand,” with regard to the need for mental health insurance. One early policy was the outcome of a collaboration between the United Auto Workers and the American Psychiatric Association, in 1966. The UAW plan provided mental health coverage to three million workers, including outpatient psychotherapy and “forty-five days of in-hospital care for ‘nervous and mental conditions.’”

In any case, during the 1960s into the 1970s as states gradually abdicated responsibility for the people they discharged people from mental institutions, the federal government assumed many of their former functions. The expansions of federal social welfare in 1965 funded not

just the health programs, but public housing and food stamps, among others. Whether or not the individuals discharged from institutions became “integrated into community,” these people — many of whom had spent their adult lives in institutional custody — could claim welfare benefits to cover some of their material needs.

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The degree to which the federal government had in fact assumed fiscal responsibility for the welfare of the mentally ill would have become apparent when it abdicated this responsibility in turn. A further shift in the significance of deinstitutionalization came with a second transformation: namely, the retrenchment of these same federal welfare programs.

Despite the interest of the federal government and some experts during the late 1970s, it may only have been with the twenty-five percent cut to the federal budget in 1980 that deinstitutionalization began to appear widely as having entailed a public abandonment of the mentally ill. The broad emphasis of advocacy on behalf of the mentally ill had been on individual autonomy—in one sense quite literally, as freedom from involuntary confinement. The critique of the mental hospital as limiting individuals’ freedom—not wrong—logically preceded the challenge of mentally ill individuals’ integration into non-institutional society, and arguably obscured it. But as federal welfare provisions were reduced, new stakes of such integration appeared *in fact*. Like many of the people who had found themselves in the



almshouses of the 18th and 19th centuries, the severely mentally ill had a hard time holding jobs, maintaining family ties. In 1962, state hospital physicians Brill and Patton had wanted to point out to readers that this same fact meant “limitations” on how much state hospital populations *could* be reduced. In a couple of decades, much had changed—but a group, the mentally ill were still at a disadvantage in functioning as the types of economic subjects that society demanded. These demands themselves obtained a new significance during the early 1980s.

In addition to the federal budget cuts generally, the so-called “disability review” conducted by the Social Security Administration between 1981 and 1984 might have hit the mentally ill particularly hard (Berkowitz and Dewitt, 2004). The new Reagan government seized on what was planned as a routine administrative procedure, already in the works, to reduce the quickly-growing disability rolls (Derthick, 1986). This was the first time most Americans had ever heard of the program (Meyerson, 1987), but the effects of curtailing it were quickly apparent. The review ended amid public outcry. It was followed by amendments to the process for disability certification, a process complex enough that there appears to be legitimate disagreement as to the implications for the recognition of mental illness, and for the mentally ill as a group.

It does not appear that the mentally ill lacked public sympathy in the early 1980. But by the time it was widely apparent that states had abdicated their traditional role, it would have been

very hard to reconstruct public responsibility for this particular social group. Mental illness had not become a socially irrelevant condition--and yet the group that suffered from it was no longer bureaucratically visible from the standpoint of any one institution. For another, by that moment, the same would have applied to any other social group. The Reagan administration articulated a new small-government ideology. Commentators from a range of political standpoints have pointed out that its politics represented just one possible response to a range of developments that had already begun to shape US politics during the late 1970s—albeit an enduring, and now familiar one. From the standpoint of that eventual solution, deinstitutionalization as policy appeared precocious. This leads us to third reason that it would have been extremely hard to re-erect public responsibility for mentally ill by the end of the 1970s: while states had abdicated their responsibilities, new actors had emerged.

## **THE NEW REGIME**

By the late 1970s there existed a new regime of treatment for mental illness. The following passage opened a report published in 1980. Its attempt to characterize the new system is worth quoting at length:

*Imagine a commodity with the following characteristics:*

- *The amounts of resources devoted to it are growing rapidly; governments, Federal, State and local, are the principal sources of financial support for the industry.*

- *Private nonprofit organizations are major providers of the commodity, sometimes with their own funds but often with governmental funds.*
- *The effectiveness of the commodity in accomplishing what it claims to accomplish is very difficult to assess.*
- *New producers of the commodity are entering the industry in substantial numbers, but each entrant is providing an identifiably different version of the commodity.*
- *The new producers, claiming that their products are as effective as those of the traditional producers, are struggling to have their products covered by insurance.*
- *Technical change has transformed the supply side from one dominated by large government institutions to widely dispersed, small, more independent providers.*
- *The commodity is so important to some individuals that it cannot be legally denied because of inability to pay.*
- *Many consumers can purchase the commodity at a price near zero, because they have “insurance.”*
- *Government agencies, recognizing these conditions, are under continuous and conflicting pressures to license and not to license new producers to restrict entry and to facilitate competition, to expand insurance coverage to encompass new producers and to hold down expenditures by not expanding it.*
- *Government agencies and private nonprofit organizations, being principal suppliers but being unwilling to seek profit maximization as a goal, engage in benefit-cost analysis that is casual at best.*

So wily a commodity was obviously enough to blow the minds of contemporary economists (McGuire et al., 1980). And yet by 1980, it was real enough demand their understanding. The report is no lonely speculative exercise—its hundreds of pages represent the proceedings of a national conference of mental health economists. It represents just a small part of the production of that new field (see also Shinnar et al. 1985, 1986). The mental health economists may not yet have understood the precise nature of the beast; but a look at the conference program reveals the problems they saw themselves as being asked to solve: “the extent to which insurance stimulates demand”; measuring “costs and benefits of alternative mental illness therapies,” the “need for improved understanding of the nature of the various

resources employed in the mental health care industry,” and, naturally, the “growing political and professional pressures for deinstitutionalization” (McGuire et al. 1980, p. 1).

Chapters Five and Six will investigate how a movement on behalf of the mentally ill could have perceived its relevant context, when. But in the 1980s, these were the circumstances within which such a movement operated. It is hardly a surprise that increasingly, over the course of the 1980s, groups that advocated for the mentally ill began to speak of themselves as a “consumer” movement (McLean, 2000). This orientation divided them from others, including some organized groups of former mental patients. The market-based system of mental healthcare delivery would eventually become the most common target of mobilization on behalf of the mentally ill (Frank and Glied, 2006; Tomes, 2006; MacClean, 1995).

Consumerism did no doubt prove to be a good framework for many. Conceptually, it had strong echoes of Szazian voluntarism, which would have appealed to some, though not all, newly interpellated mental health consumers (see Goldstein, 1980; MacLean, 2000).

But their circumstances as consumers also divided the mentally ill. From the 1980s onward the relevant literature makes continual references to class differences *among* ex-patient groups (Brown, 1984; Chamberlin, 1990; MacLean, 1995; MacLean, 2000). These class differences may indeed account for expressed ideology, as many authors suggest. But they would also in many cases have also corresponded with differences in insurance coverage that entailed

wildly different landscapes of mental health “services” (MacAlpine and Mechanic, 2000).

Further however, the thanks to the historical role of employers in the provision of health insurance; the severely mentally ill at a disadvantage on the labor market were at a disadvantage here too. In the year 2000 over one in five was estimated to be uninsured; 37% relied on government insurance (MacAlpine and Mechanic, 2000). Thus as a portion of *all* healthcare consumers, the mentally ill were comparatively weak. In the healthcare patois of today: claims regarding the “mainstreaming” of mental illness in such a system, were belied by continual calls for “parity,” with other types of health services.

The variety of potential consumers needs and priorities also meant that the “consumer” perspective was mobilized by both healthcare providers on one hand, and advocates of managed care and other cost-saving strategies on the other (Sharkey, 1994; Findlay, 1999). In the new environment, elements claiming to speak on behalf of the mentally ill appeared in opposition as often as they did in alliance: “‘Consumer’ groups can now be found on any side of a given conflict concerning mental health provision [...] The diversity is complicated by consumer advocates’ relationship to other[s] in the field” of mental health, A case in point is the funding of consumer groups by drug companies,” (Tomes, 2006, p. 726). Thus, not only were the mentally ill divided, As consumers in the private healthcare system that emerged, the mentally ill were differentially positioned as individuals, disadvantaged as a group, and enfeebled as a collective actor.

The dynamics that made the social abandonment of the mentally ill appear so irreversible would come to be familiar over the coming decades. But whereas they would become widely salient to in an important sense it *could not* have been so for makers of the movement into the 1970s. In the next chapter I show that in fact, there is scant evidence that deinstitutionalization was undertaken by states for the reasons that (what would later become known as) later “privatizations” typically were. Deinstitutionalization was a true reversal.

## **THE SCOPE OF REVERSAL**

I hope that the rest of the dissertation will make clear the value of seeing deinstitutionalization as a reversal. The observation that the significance of deinstitutionalization was transformed is the necessary starting point from which to recover the drama in this process, that is, to understand the actors that drove it in ter. For one, seeing the reversal in deinstitutionalization allows us to reopen an investigation into the nature of states’ action as their responsibility for the mentally ill ebbed (Chapter Two). Second, it allows us to bypass an explanation of movement success or failure, and ask another question about collective action behalf of the mentally ill—namely, why, as the significance of deinstitutionalization was being transformed in fact, did the movement not react differently, for example, to define a new goal?

The question demands that we —of how to determine when a movement has ceased to be a collective actor (Chapter Five)—and the related methodological problem of obtaining a

consistent standpoint on the flow of relevant events as they appeared to contemporaries (Chapter Three).

My understanding deinstitutionalization as a reversal shapes the rest of the dissertation; and I of course help that it can be theoretically useful in other contexts. Let me close by clarifying the concept of reversal in the abstract of the particular case of deinstitutionalization.

To restate: a reversal an action transformed in its significance as it is underway, by developments in another domain of social life. Reversals are thus different from the simple fact of history's moving on, and taking a different course. The success of the French Revolution of the eighteenth century *in some sense* “reversed” the Catholic monarchy's suppression of the Albigensian Heresy over the course of the eleventh — but it was not a reversal in the sense considered here. Both the latter action (suppression) and the interactive sequence in which it was embedded (heresy - crusade - suppression) were complete by the time the new direction occurred. In an important sense, they could not be revisited: the Cathar heretics had been wiped out, their religious texts destroyed, and the material remnants of their culture purged from the territory that is now southern France. In what I define as reversals, the transformation happens when further action by the *same* actors--or actors in the same roles— is still possible.

Reversals are also not “unintended consequences.” Not all unintended consequences entail reversals. Action based on incomplete knowledge, on misperception; action that is unsuited to its proximate aims; action that’s effectively thwarted by (sole) virtue of its target’s response—all can produce consequences that the authors did not intend. There are many ways for actors to fail. But the mere fact that they *do* fail does not imply the existence of reversal as the relevant mechanism. The mechanism of interest involved in reversals depends on the nesting of social organization across scales or domains, given the relevant independence of these domains. Reversals can happen inasmuch as social actors are part of multiple worlds at once. Action in one world may thus be affected by transformations in another.

Conceptually, reversal does not depend on the subjective assessments of the actors involved.

If we can have unintended consequences without reversals, reversal without unintended consequences is also possible. Consider Philip Kuhn’s account of what went wrong in late imperial China: the Ching dynasty, Kuhn argues, outlasted a series of heterodox religious insurgencies because provincial gentry took new initiative in military leadership of their communities. Over time however, the gentry’s absorption in local affairs weakened their investments in the imperial center, making coordinated action across the territory more difficult. It was thus easy for the empire to break apart upon the “opening” of exchange with Europe. Kuhn’s account is an example of reversal that makes no reference to the “intentions” or subjective perceptions of any of the actors in this story: Empire, provincial gentry, peasants, heterodox insurgents, or Europeans.



Thus the definition of action's "significance"—when it comes to reversals—is fundamentally social structural. Actions have implications within some set of social relations-- and actions that are reversed come to have a *different* implications for those *same relations* at a later point in time.

It's reasonable to assume reversals are frequent. All sorts of actions are constantly being transformed into something else. Residents of rural France find that their best attempts to make traditional farming succeed in the 20th century have ensured their celibacy, and so too the end of the farms (Bourdieu, 2002). Sharecroppers organize their own collective distributors, but after wholesalers in turn refuse to sell to them, the collectives fail (Schwartz , 1970). In the background of Philip Selznick's study, people support grassroots organizations only to find that while they have managed to shift the behavior of larger organizations, they have in the process also been transformed.

Successes and failures are frequent too, but not all of them are interesting. Reversals are transformations that can be described entirely in relational terms, but they are invisible without a standpoint. Reversals can be defined social structurally, but that is not the reason they are interesting to *us*. As Weber would have it, reason that historical events are interesting are because they are *significant*, from the researcher's own standpoint.



## CHAPTER TWO: DEINSTITUTIONALIZATION AND THE STATES

By the late 1970s, deinstitutionalization had been named. Though not yet the subject of post-mortems in the *New York Times* or public self-reflection on the part of psychiatry, in certain circles it was beginning to arouse controversy. The lines of these conflict, however, were not yet so well-drawn. An exchange, published in the health policy journal *The Milbank Quarterly*, will illustrate the debate as it stood in 1979.

The exchange was between Stephen Rose, an economist then at SUNY Stony Brook's School of Social Work, and Gary J. Clarke, on hiatus from his career as a civil servant, and working at a nonprofit called the Intergovernmental Health Policy Center. Rose's lengthy article offered a critique of states' recent mental health policies—the pitch of its criticism outstripped anything yet published on the fate of the mentally ill “in the community.” Clarke's response was an essay of less than ten pages titled “In Defense of Deinstitutionalization.”

The Rose argument, in brief, was that deinstitutionalization was fiscal policy. Distinguishing himself from the growing ranks of specialist observers asking what had gone wrong with states' mental health provision, Rose argued that precisely nothing had gone wrong: By transferring the mentally ill out of public institutions wholesale with the aid of federal social welfare subsidies, states in “fiscal crisis” successfully reduced the burdens on their own budgets. The political agents who promulgated these policies not only won kudos for fiscal

responsibility, they curried favor with private sector interests that would benefit from the care of the mentally ill—the nursing home industry, private psychiatric facilities, board and care operators, and so on. Rose made his case by calculating the yearly per patient sum that New York State could expect to save by returning a single state hospital inpatient to community care, and drawing federal aid. Looking at the numbers in 1974, factoring in benefits from the relevant federal sources, he put the figure at a conservative \$9000.<sup>2</sup> How much money had deinstitutionalization then saved New York? On the basis of Rose’s estimates, “in 1968 dollars, the amount saved would be somewhere in the vicinity of \$585 million per year” (Rose, 1979, p. 576).

Finally, the *coup de grace*: Rose argued that the ideology of community care, far from propelling deinstitutionalization, was epiphenomenal of it. The notion that care outside of institutions was preferable -- or indeed, that “care” was what those released from state mental institutions would receive from the private sector -- was worked up justify state budgetary strategies. Rose laid the blame with “the mental health professions.” Vocationally fixated on the individual as the object of decisionmaking, psychiatrists had been blind to the real drivers of the policies they endorsed, instead, Rose unkindly concluded, “see[ing] themselves as the tail wagging the dog” (1979, p. 455).

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<sup>2</sup> “If an overestimate of \$1,500 is added for various services, the total still comes to just over \$4,600, some \$9,000 less than the annual per person cost of hospitalization. In New York alone there are 50,000 fewer inpatients in 1979 than there were in 1968, and more than 65,000 fewer than in 1955; the amount of state money saved thus becomes all too apparent as a motivation for complying with federal incentives to deinstitutionalize. In 1968 dollars, the amount saved would be somewhere in the vicinity of \$585 million per year” (Rose 1979: 576).

Clarke's brief response to Rose hits back against a picture of deinstitutionalization that is, as he sees it, "cynical", "limited" and "wrong." He opens by acknowledging that, "in a public policy sense, deinstitutionalization has indeed fallen on hard times." Adopting the role of long time observer of state health policy, who cares very little for the times, Clarke goes about setting the record straight—attacking Rose's understanding of the history of deinstitutionalization, state budgeting, and the role of the federal programs.

First, Clarke argues, Rose's calculations are flawed: Assessing the savings involved in deinstitutionalization on a per-individual basis ignores the relatively high fixed costs of running state mental institutions. Conversely, by focusing only on the direct costs to states of care in private settings, Rose greatly exaggerates their actual savings. This, Clarke explains, is not how budgeting actually works: states "factor in the costs that [they] would necessarily incur for former patients as recipients of other social services," citing the example of Medicaid—a program whose costs states governments are required to share—and for which recipients of SSI, one of the federal programs on which Rose based his calculations, are statutorily eligible. This is why, Clarke suggested, states had seen only *relative* reductions in the amount of their budgets dedicated to mental hospital care (p. 471).

Clarke goes on to fill in for readers, what Rose's picture leaves out: namely, the dehumanizing conditions of the state mental hospital at midcentury. It was the efforts of reformers responding to such conditions, Clarke writes that, "led to a fortuitous marriage between state

deinstitutionalization efforts and two federal programs,” Medicaid and SSI. Here Clarke wants to distinguish carefully between the spurious model of state action in mental health as *driven* by fiscal concerns, and thought that states weigh such concerns in formulating policy—which he clearly believes to be true. While federal programs abetted the reduction of state hospital populations by reducing the relative cost of alternative arrangements for patients “who could manage in the community,” they thus hardly *explained* the policy of deinstitutionalization. Having rejected Rose’s argument about the part played by the “federal windfall” in deinstitutionalization, Clarke offers another: if anything, federal grants “probably help account for its success.”

The style of Clarke’s essay does not leave much room for explicit editorializing. But the message is clear enough: that history will likely judge deinstitutionalization a success. For the moment, he writes, it “must be seen in a realistic light as a relatively new, almost experimental, complex effort to deal with a group of extremely poor and severely disabled citizens.” Not all states’ efforts have worked equally well, and some individuals have suffered. Clarke acknowledges all this—but urges caution, patience, and commitment. His response to Stephen Rose closes with a counterexample, illustrating one of successes of community care: In St Louis, former mental patients live together in shared housing, where they receive vocational training, assisted by a small staff. (“Funds for the program have been gathered from a variety of sources, including SSI, Title XX (social services), Rehabilitative Services, Medicaid, and others.” (1979, p. 474)) In the future Clarke predicts, “a slower rate

of exodus from state hospitals, better coordination of existing programs, adaptation of already successful models of community care, and innovation [...] at the fringes of public policy. Given the problems of the past ten years, this may be the best medicine that could be prescribed.” (1979, p. 476)

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There’s no evidence that Stephen Rose ever responded to Gary Clarke. He didn’t have to. The developments of the coming years would make Rose the obvious winner of the debate. As described in the previous Chapter, the new Reagan administration did away with the Community Mental Health Centers program, returned the remaining funds to states as block grants, and formally ended the federal role in mental health policy. Significant cuts in the new administration’s federal budget rolled back many of the social welfare programs that had been, for example, supporting the industrious ex-patients of St Louis. However realistic Clarke’s incrementalism was in 1979, the regime into which it had been projected was over.

Academic social scientists, meanwhile, embraced Rose’s argument and others like it. Sociologists hastened to produce more research into the ways that cost cutting had resulted in the commodification of care of the mentally ill—and for that matter, the elderly, juvenile offenders, and other troublesome populations. Less than three years later, the *American Behavioral Scientist* published a special issue on deinstitutionalization. The introduction cited

Rose's 1979 article, along with Andrew Scull's work on the decarceration of mental illness (1977, 1979), as key exemplars of the new "social control/political economy approach" (Warren 1981).

The editors also clarified what the new approach had replaced. The "labelling" theory of deviance, associated with Goffman (1962), Scheff (1974) and others, had theorized its object as arising through individuals' patterned interactions. The editors observed that the dissolution of the mental institution and its crystallized interactional forms had *not*, however, spelled the end associated forms of deviance: the mentally ill were still here. History had discredited their predecessors—but the editors also appeared to blame them for creating it. The framing perspective on deviance had "convinced those of left and liberal persuasions," that a dismantling of the mental institution would suffice to reintegrate the mentally ill (Warren 1981). The collective delusion for which Rose had originally accused psychiatrists, now appeared as something in which sociologists had played a central role in generating. "What is real," the new generation offered to clarify, "is the transfer of responsibility for 'social junk' from state budgets to various combined welfare-private profit systems that cost the state less and provide numerous entrepreneurial opportunities" (1981, p. 725).

"Social control/political economy" as the new sociological approach to mental illness does not appear to have seen challenges during the eighties and nineties, as private firms took over the delivery of formerly public services, and welfare state retrenchment came into view (see



eg Schurr 1984; Staples 1990; Conrad 1992). Like Goffman's work on mental hospitals, the analysts had illuminated the institutional realities around them. Sociological research on the mentally ill and mental illness of course continued (Gronfein, 1985a; 1985b). Recent work on the autism epidemic suggests that different categories, in addition to different treatment modalities, may have replaced such a broader frame as grounds for claiming public support (Liu et al., 2010; Eyal et al., 2010). But the discipline has announced no bold new theoretical approaches to mental illness as such since the early 1980s. As state hospitals themselves closed during the 1990s, there were few return visits by social scientists (cf. Dowdall, 1996).

Scholars of the decarceration generation apparently remained quiet as their colleagues began study the dimensions of the prison boom (for an early review, see Sampson, 2000). Academic work on the relationship between the two systems has come largely from law, public policy and psychiatric epidemiology (respectively for examples: Raphael, 2008; Harcourt, 2005, 2011; Lamb and Weinberger, 2005; Prins, 2011). In the era of mass incarceration, not many sociologists have been inclined to revisit the state hospital system. Since 2008, US prison populations have in fact been in decline (Glaze and Parks, 2011), as demands from the left for abolition resonated with increasingly bipartisan calls for reform. And yet in some respects when it comes to the eclipse of state mental hospital, we have no better grasp of the plot today than we did when Stephen Rose and Gary Clarke had their exchange in *The Milbank Quarterly*.

## THE WELFARE STATE THESIS SINCE 1979

In this Chapter I revisit the question of states' role in the process of deinstitutionalization. History settled the argument between Rose and Clarke in several respects: For one thing, the moral verdict on deinstitutionalization in the US went in Rose's favor. Rose's insights about the commodification of mental health services were prescient. Even if his argument that deinstitutionalization "*establish[ed] the basis for transferring funds to the private sector,*" (p. 725) wasn't strictly true historically, it eventually became so. That is, as we saw in Chapter One, that is, the growth of the healthcare marketplace and the rise of the politics of retrenchment that underwrote deinstitutionalization as reversal, making a new public system for the support of the mentally ill politically impossible from the early 1980s.

Perhaps for these reasons, the question about *mechanisms of state action* in the debate between Clarke and Rose remains frozen in history. I pick up the debate more or less as they left it, and attempt to adjudicate. Specifically, I focus on the role of the expanded federal welfare programs, which figures in both men's arguments. The task of this Chapter is thus not to explain what caused deinstitutionalization, but to distinguish different possible ways in which federal policy might have affected states' action with regard to the mentally ill, and to consider their plausibility. I do so by examining the timing of states' patterns of deinstitutionalization.

The rest of the Chapter proceeds as follows: I review work that has advanced some version of the Welfare State Thesis (WST)—namely, that federal welfare policy helped to drive deinstitutionalization. I then review the variety of federal programs that might plausibly have affected states’ behavior. I distinguish three mechanisms through that could have mediated the way state actors interacted with these programs, and the consequences we would expect in each case for states’ deinstitutionalization trajectories. Finally, I examine data on rates of mental hospitalization by state for the evidence they provide.

Indeed, patterns in states declining rates of public inpatient hospitalization are broadly compatible with the Welfare State Thesis. But neither Stephen Rose’s version of the argument, nor the version subsequently embraced by scholars of mental health policy holds up to scrutiny.

The idea that federal social programs drove deinstitutionalization seems to originate in the Government Accounting Office report of 1977, mentioned in the previous Chapter. The report is several hundred pages long, damning—though not necessarily of any one actor in particular, probably the Department of Health Education and Welfare comes off worst—and none too clear on whether “deinstitutionalization” is the goal, the symptom, or both. (For example, the report *both* faults the Medicaid program for allowing the transfer of state hospital patients to inappropriate facilities, and also recommends that because Medicare will

only fund a limited number of days of custodial care, it should be amended to facilitate “deinstitutionalization.”)

Even so, the GAO report, based on interviews conducted across the federal agencies, and foot leather investigations into the care of mental patients in states representing five of the DHEW’s twelve regions, represented a massive research undertaking and was clearly a revelation when it appeared. It appears to have been responsible for making what was going on in states mental hospital systems legible from a national standpoint, and in giving the process a public name. Both Clarke and Rose cite the report. It is also cited in Scull’s sociological monograph of the same year (1977), and nearly every social scientific treatment of deinstitutionalization published since. Crucially, the GAO report made the connection between the uniformity of downward trends in mental hospital inpatient populations across states, and the policies of the federal government, in particular in the areas of health and welfare.

Since the appearance of the GAO report, scholars have revisited the connection between federal welfare policy and the depopulation of state mental hospitals. Grob takes the argument quite seriously, noting that disability insurance programs introduced as early as the 1950s may have enabled deinstitutionalization (2014). Lerman’s case studies of California conducted in the late 1970s show that many of California’s former state hospital patients lived in new arrangements which though run by private operators could fairly be described as “involuntary

confinement,” he also makes the case that the state used of federal programs to shift the burden of patient care (Lerman, 1980; 1982).

Psychiatrists and psychiatric epidemiologists too, have taken an interest in the argument:

Goldman, Adams and Taube (1983) analyzed unpublished data from the NIMH, and like others, concluded that the reductions in the inpatient census in public mental hospitals has *not* in fact been reflected in a corollary shift to “non-institutional” care. They point to the “introduction of Social Security benefits, including Supplemental Security Income (SSI), Medicare and Medicaid” (132) in shifting patients to other types of facilities, like nursing and board and care homes, but do not demonstrate the linkage. Frank, Goldman, and Hogan surveying the role of the Medicaid in the delivery of mental health services historically, argue that the program played a significant role in enabling the shift away from custodial care (2003). E. Fuller Torrey’s history of mental health also identifies Medicaid and SSI as the real driver of deinstitutionalization (2015). If Clarke’s mechanism is a fundamentally whiggish one, in which state governments as stewards of the mentally ill do the best job they possibly can, using Medicaid to place patients in noninstitutional care “where appropriate,” Torrey tells a Burkean version with the same basic causal elements: Federal involvement in mental health was an unqualified disaster, with the NIMH distracting attention while the states used Medicaid to “dump” their wards (2015).

William Gronfein's 1985 study appears to have provided some basis for Torrey's version. It stands out among examinations of the welfare state thesis, in that it may be the only study of the influence of federal spending that presents findings based on relevant state-level data nationally. Gronfein looks for an association between the existence and activities of Community Mental Health Centers, and states' inpatient decline in state mental hospitals; he finds none. Instead he finds that during the same period, "Medicaid payments are very strongly associated with the amount of deinstitutionalization experienced by a state" (1985: p. 201).

"The data are consistent with a model in which Medicaid funds are used as a way of transferring costs from the states to the Federal government and in which one of the influences on the degree to which state hospital systems declined in the early 1970s was a state's involvement in the Medicaid program," Gronfein concludes (1985: 202). The study has been cited not just by Torrey, but indeed by every one works above that post dates it, as well as by Mechanic and Rochefort (1992), Link and Phelan (2013), Grob (2014), among others.

What is unsatisfying about the body of work on the welfare state thesis as it has developed since the era of the Clarke and Rose debate, however, is the lack of critical attention to the *mechanism* through which the federal influence might have exerted this effect. Though

Gronfein, exceptionally, does look at state patterns, this is true of his analysis as well—he offers a mechanism that fits his finding, without considering alternatives.

Thus on one hand, since the appearance of the GAO report in 1977, a variety of federal spending programs have been proposed as influences on state mental health policy—programs which were introduced over a period of decades, and which would have affected states’ behavior in different ways. On the other, writers on mental health policy have cited the welfare state thesis in connection with their preferred mechanisms of federal influence when it comes to state mental health policy, largely unhampered by evidence from the states. The next section thus steps back to enumerate the sources of federal spending that might have shaped states state behavior during the relevant period. It then identifies three mechanisms of influence, with distinct implications for inter-state patterning of deinstitutionalization.

## **FEDERAL WELFARE STATE EXPANSION**

Table 1 below represents federal transfer programs that could potentially have speeded the declines in public mental hospital populations. Given our concern with the role of welfare state expansion specifically, it focuses exclusively on *federal programs* that effected *significant transfers* of funds—that is to say, that redistributed resources outside of the federal government itself—whether to states, as directly to individuals or as payments made on behalf of beneficiaries to the private sector. Thus the NIMH program that funded community-based

mental health clinics has been included, but, for example, the founding of the National Institutes of Health and the National Institute of Mental Health has not.

Listed are both programs that have been named specifically in the context of arguments for the WST, as well as those that have not been considered but which should be according to the same logics. Scholars taking the “social control/political economy” perspective have documented the role of privately-run custodial facilities including nursing homes and board and care facilities in the lives of former state hospital patients (Estes and Harrington, 1981; Segal and Aviram, 1976; Scull 1977; Staples, 1990). Programs that would have subsidized nonprofit and for profit custodial care outside of the public sector have thus been included.

Arguments like Gary Clarke’s would direct attention less to the existence of markets for care per se, than to former state hospital patients’ ability to be “supported” in one way or the other, in the community—without income from regular, full-time employment. Thus federal income support programs for the both the elderly and disabled have also been included.





Table II-1: Programs of Federal Spending, 1945-1974. (Continued next page.)

DATE	PROGRAM	PURPOSE	FUNDING STRUCTURE, SOURCES & ADMINISTRATION
1946	Hill-Burton hospital construction program	Authorizes federal funds to states in the form of grants (and low interest loans) for hospital and nursing home construction.	Grants in made by Public Health Service for construction subsidies. Funding was allocated by state, and awarded to localities on the basis of those local plans.
1950	Aid to the Permanently and Totally Disabled (APTD)	New public assistance program for the disabled, on the model of programs for the elderly (OAA), dependent children (ADC), and the blind.	Grants in aid to states, conditional on a state's matching per-beneficiary contributions. Funds to be paid as cash grants to individuals, administered through states' welfare departments, usually disbursed through county and local welfare offices.
1950	Medical Assistance for the Aged	Definition of federal assistance broadened to authorize payments for medical services, Payments authorized <i>within</i> existing per-beneficiary maximums stipulated by Federal legislation.	Grants in aid to states for cash transfers to disabled individuals. Eligibility determined and funds administered through states welfare systems. States participate in the program at their discretion.
1952	Social Security "freeze" for the disabled over 50.	This "program" was the political compromise arrived at through early unsuccessful attempts to legislate a national disability program (Berkowitz 1987).	Social Security Administration will "freeze" the benefits of employees who have been paying into social security, so that they can eventually claim benefits equal to those they would have received if working continuously.
1956	SSA institutes direct to vendor payments on behalf of instituted.	NA	Social Security Administration creates a separate system for administering vendor payments under OAA. The SSA thus will pay directly into state funds, from which payments vendors (health care providers) are made on beneficiaries' behalf under the Old Age Assistance program.
1956	SSDI Social Security Disability Insurance (SSDI)	Federal Insurance coverage to supplement states' Workmens Compensation laws. (In contrast to states Workman's Compensation laws, it provides support for people whose inability to work is medically demonstrable, but <i>not</i> incurred in the workplace.)	Social security administration makes direct monthly payments to individuals over fifty who become "totally and permanently disabled", in amount scaled to beneficiary's past earnings. Determinations of disability must based on certification that medical need renders the individual incapable of work. Determination of individual eligibility is done by state disability offices (usually housed within state Departments of Welfare) and subject to federal (SSA) review.

1960	Kerr-Mills program of Medical Assistance for the Aged (MAA)	Medical assistance first authorized for individuals not on the Federal welfare rolls. Authorizes Federal funding for care of "medically needy" over 65 who do <i>not</i> receive OAA.	Grants in aid to states for medical care, including vendor payments. State participation is discretionary. Federal funding to "match" states' at a per beneficiary rate. Introduces the so-called "IMD exclusion": it will not finance care to individuals in institutions for mental disease, recognizing this as domain of the states. An exception (to the IMD exclusion) is made for individuals over 65.
1960	Amendments to Social Security Disability Insurance	SSDI payments extended to workers of all ages and their dependents.	No change in structure of the the SSDI program
1963	Community Mental Health Centers Act	To fund the construction and staffing of community mental health centers.	Administered by NIMH, which is makes payments in the form of grants for both construction and staffing.
1965	Social Security Act Title XVII (Medicare)	Medical insurance program for those 65 and over that covers hospitalization.	Funded by federal government through general revenues and payroll taxes, paid to healthcare providers on behalf of individuals. Effectively reimbursed up to 150 consecutive days of care in a state or private mental hospital, and a limit of 190 over an individual's lifetime.
1965	Social Security Act Title XIX (Medicaid)	To financed medical care for individuals receiving federal public assistance, and other low-income individuals, the "medically indigent."	Federal grants in aid to states, for approved plans for medical assistance. To cover all beneficiaries of federal programs, and those defined as medically indigent at state's discretion. States participate at their discretion until 1970, at which point it becomes mandatory. IMD exclusion with exceptions for both individuals under 21 and over 65.
1972-1974	SSI	Federal government takes over income support programs for the elderly and the disabled (OAA and APTD). Beneficiaries under the new program would automatically qualify for Medicaid benefits.	Federal funding, plus any state supplement, paid directly by SSA to individuals. Initial eligibility decisions under the federal definition to be made by state-staffed disability determination offices. All individuals covered under state-run APTD (welfare disability) programs before the end of 1973 were guaranteed to receive federally-administered SSI. Determination of eligibility could be made while individuals were in state care. Disabled individuals living in state run institutions and public halfway homes and are excluded from SSI.

I exclude from consideration some of the programs that Clarke points to, including some of those relied upon, for example, in the case of the Missouri aftercare program, as well as some of those mentioned in Chapter One. Federal grants for the construction of public housing, for instance, might have made it much easier for mentally ill individuals to move out of institutional care without full time employment. But considered for their known consequences, such programs would not have been uniform enough to shape the behavior of states with respect their state hospital populations in a systematic way.

Given my window of observation below, programs of federal spending from 1945 through the 1980s are considered as candidates for inclusion. Thus the first of these programs was initiated in the year following the Second World War; the last was initiated in 1972 and its implementation was completed in 1974— widely considered the high water mark of American liberalism (e.g. Tani, 2015).

Table 1 exists to bypass a tedious discussion of the particular details of each program. Let me simply offer three general observations about them collectively. Together with the information in the Table, these should suffice to distinguish the different ways in which welfare state expansion at the federal level could have affected state patterns of deinstitutionalization.

First, Not all federal spending programs implicated state governments in the same way.

Some programs did not involve states' governments at all--though the effects on their deinstitutionalization policies may have been felt for other reasons. The Hill Burton hospital construction program is one: designed to attract financing for the construction of new hospitals, it vastly increased the number of of the non-public hospital beds in the country (Starr 1982; Statistical Abstracts of the US 1950, 1960, 1970, 1980). Likewise Medicare did (and does) not directly touch states governments; the federal government would pay directly for medical care on behalf of the aged through fiscal intermediaries -- insurance companies.

“Grant in aid programs” mostly *do* implicate states governments (exceptions in our context are noted in the Table). As described beautifully by Martha Derthick, they do so by making states the agents of the federal purposes (Derthick, 1968). On this structure, states receive federal money on the basis of plans they design for spending it, and the relevant federal agencies seek to ensure state “compliance” with its plan. Derthick’s own work carefully examines the power relationship thus established between federal and state government through such grants. The treatment is particularly careful, one imagines, because it is this power relationship that was so explosively thematized by the southern states facing pressures to desegregate, during the period of and her, and our, concern. Other scholars have affirmed that that in fact, while the issue of “states rights” is today best known for its rhetorical role during desegregation, the matter of states relationship to the federal government as mediated

by federal grants in aid was a not *just* rhetorical; it was amply litigated between states and the federal government starting from the late 1940s (Tani, 2012; 2016).

Second, Medicaid, the federal healthcare program for the poor, on which so much WST-related attention has focused, was not the first the first grant in aid program potentially relevant to the institutionalized mentally ill. That is, based on the logic of those who have argued Medicaid drove deinstitutionalization through patient dumping, it was not the first relevant program. As noted in the Table and in Chapter One, Medicaid excluded “Institutions for Mental Disease” from receiving payments. But indeed, as Table 1 makes clear, state direct to vendor payments were in operation from 1950, the federal government paid into these funds from 1956, and the so-called IMD exclusion dates from the 1960 “Kerr-Mills” program for the medically indigent.

Third, taken together, the programs in Table 1 make vivid a feature of postwar health policy in general: federal welfare state expansion executed a major redistribution of wealth *through existing markets*. This observation about social policy in general, and relevant periodization of US political development it yields, comes from Ira Katznelson. The social insurance programs established during the New Deal represented an attempt to change *qualitatively* the way the state mediated class interests, Katznelson observes; the Great Society effected a far more substantial *quantitative* transfer of wealth, without attempting similar changes. The latter was typical of the general tendency in US social policy after the 1940s, which was thus, in one

sense, continuous with pre-WWII welfare state expansion, and in another, a fundamentally conservative departure (Katznelson, 1989).

Katznelson's insights apply nowhere better than in the arena of health. In response to the Truman attempt at universal healthcare during the late 1940s, the American Medical Association campaigned aggressively against "socialized medicine" and won. In this fight, unions were not unequivocally helpful. Owing to the exemption of fringe benefits from wage freezes during WWII, they had become invested in their own role as purveyors of health insurance (Starr, 1982). As private health plans spread during the 1950s, the costs of healthcare increased rapidly (Starr, 1982; Price and Cooper, 1968). Both Medical Assistance for the Aged (MAA or the Kerr-Mills program), effective 1961, as well as the Medicare and Medicaid programs in 1965 were designed to "integrate" those left out of this system.

Medicare and Medicaid still left many Americans uninsured. But nearly all observers agree that the subsidies that they channeled so massively grew, and changed, the healthcare market. In this particular sense, the effect of programs of medical spending listed in Table 1, would have differed from those of Medicare and Medicaid only in magnitude.

It will help to get a sense of the scale of these changes. A 1963 report from the Senate's Special Subcommittee on Aging complains that "the congressional intent to extend assistance to a new type of 'medically indigent' persons through MAA has been frustrated," pointing out

that the \$580 million spent through the Kerr-Mills program authorized three years earlier, represented yearly only 10% of the total national costs of care of the population over 65. In 1965, before Medicare and Medicaid went into effect, vendor payments for medical provision were 1.5 billion a year nationally (Tax Foundation, 1968). Federal spending on Medicare in fiscal year 1968 was \$5.1 billion; spending through the Medicaid program was \$3.6 billion, about half of that from federal matching grants— this would have excluded the other federal sources of medical vendor payments that existed at the time.<sup>3</sup> Following the enactment of Medicare and Medicaid, the growth of health care costs outstripped the rise in the Consumer Price Index by 3-1, and one 1975 observer—who happens to be Gary Clarke—points out that during the same period, “hospital and nursing home costs accounted for about 70 percent of all Medicaid costs, and these two sections of the health industry were soon to be singled out for proposed regulatory schemes to control health care costs” (Clarke 1975: 6).<sup>4</sup> In 1975 the Medicaid program paid vendors \$12.8 billion. One can only imagine what the Senate Subcommittee investigating Kerr Mills twelve years earlier would have made of \$7.6 billion, —the equivalent inflation adjusted figure—but note that in 1975 the federal government was spending more on its program for the medically indigent *alone* than would have been needed in 1963 to cover the medical costs of *everyone over the age of 65 in the country*.

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<sup>3</sup> Data on Medicare and Medicaid spending in FY 1968 and on vendor payments are from the Tax Foundation, 1968.

<sup>4</sup> “Medicare and Medicaid thus have benefited health care providers as much as they have aided the-aged and the needy. And they certainly aided in the escalation in the late 1960s in the cost of health care, particularly care in a hospital,” concludes a report issued by the Department of Health Education and Welfare — admittedly not a disinterested party —in 1976 (1976: 124).



Table 1 captures a set of policies that worked, in a variety of ways, to subsidize the growth of a system of medicine under private control.

We can thus distinguish three *different* mechanisms through which the expansion of federal welfare state policy might have patterned states' behavior:

1. *States used grant in aid programs to shift the costs of care of the mentally ill*

If the “dumping” hypothesis suggested by Gronfein, Torrey and others is valid, we should see marked acceleration in the declines in state hospital populations following the introduction of relevant policies. These would include both Kerr Mills and Medicaid.

Further, if as Stephen Rose suggested, deinstitutionalization indeed represented a cost-cutting measure, we should expect to see its onset coincide with, as he says, “fiscal crises” in particular states. We might also tend to expect poorer states to drive their inpatient rates down earlier, historically.

2. *The growth of the private healthcare sector effected by postwar federal policy may have exerted a “pull” of patients out of state hospitals.*

Paul Starr illustrates how the healthcare marketplace that federal policy helped to grow created a continual need for innovation; in his words it “demanded to be fed,” (367). It created pressures for providers to diversify, for legal non-profits to “outsource” potentially profitable services; indeed in the 1930s market expansion had been responsible for the invention of private prepaid insurance — a solution to the fiscal peril faced by newly constructed non-public hospitals. Sharkey and others have argued that the growth of private mental hospitals during the 1980s was one such response on the part of a hospital industry by then being plagued by federal and employer-led attempts to curb costs (Sharkey, 1994). The work of some of the “social control” sociologists is also vividly suggestive of some of the violent ways in which market actors wrenched social junk from states.

But might not the process of commodification have been gentler? In particular, seen from state hospital inpatient rates, it alone would probably have looked different than what Rose—now with a different argument in mind — imagines, when he argues that states acted entrepreneurially, hawking their mental patients to win points with capital. The last Chapter proposed that faced with the introduction of new options like general hospital care, the actual or prospective inpatient population of states mental hospitals who could afford to experiment, began to avoid them. As both private and government health insurance expanded, an increasingly large pool of people might have simply been able—or enabled—to avoid state hospital care. We might be inclined to imagine a cascade process, with better-resourced patients leaving the mental hospital first, and then, with subsequent innovations on the part of

healthcare providers, the somewhat less well resourced ones, and so on. Such a process would appear in states inpatient hospitalization rates as a gentle decline that accelerates, as more of Hollingshead and Redlich's "majority Class IV and V" patients are served.

Such a process could occur without concerted action on the part of States Mental Health Authorities to dump patients, and irrespective of their administrative structures. It is tempting to say that it could happen completely irrespective of the behavior of states—but of course, that is not exactly so. Given the regime that existed around mental illness, all sorts of things would have had to be done to smooth the expansion the way for market actors to turn social junk into important commodities. States legislatures would have had to enact and repeal laws; states health and welfare agencies would, eventually, have needed to set up systems for contracting with private providers. Proactive work on the part of states governments could have helped to ensure that the expansion of the mental health marketplace proceeded in an even fashion.

Finally, a third possibility:

3. *States committed to resisting federal authority may have moderated their uptake of discretionary grants in aid, in turn delaying their deinstitutionalization through either of the other two proposed mechanisms.*

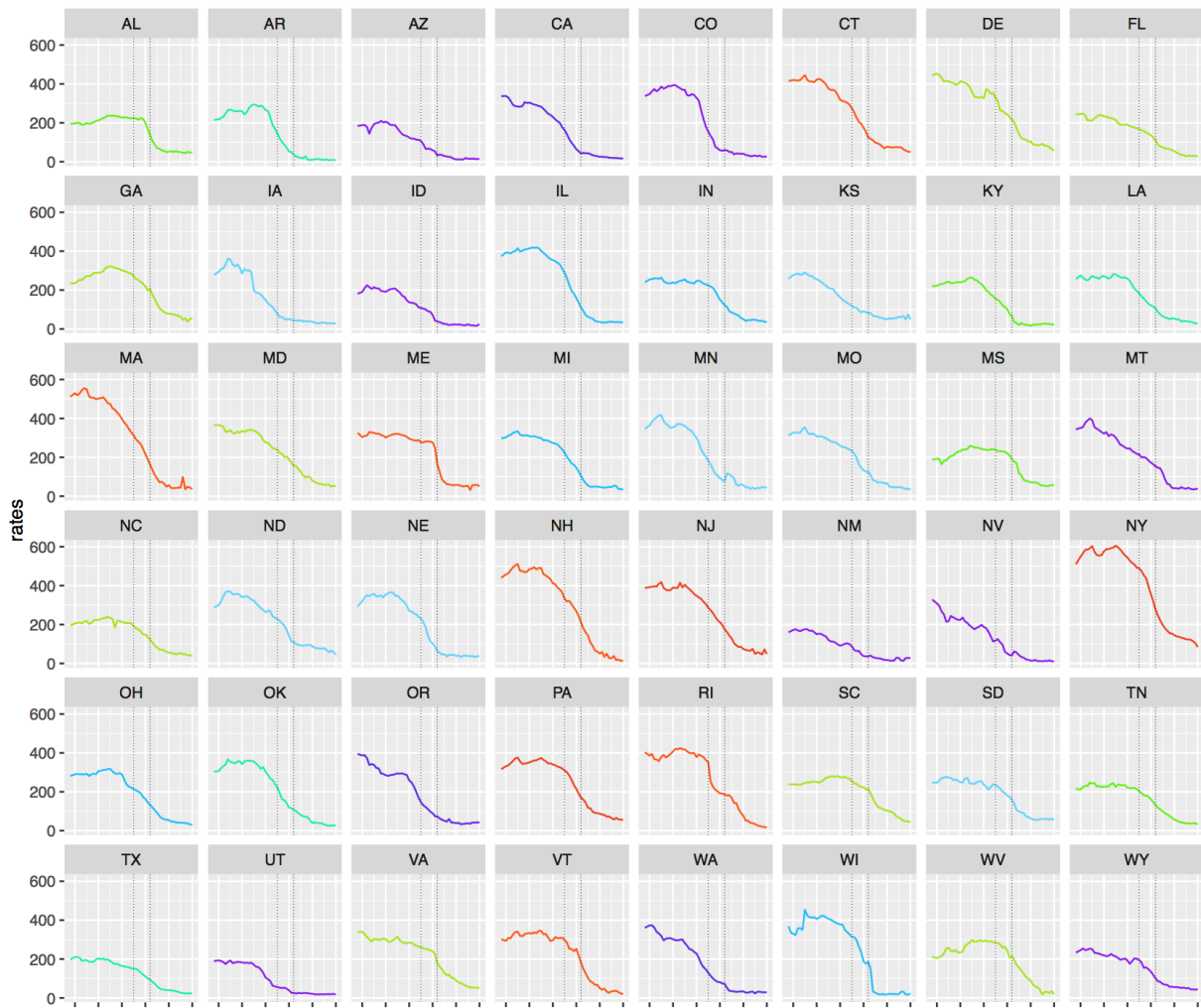


Figure II-1. State trajectories of deinstitutionalization, 1938-1990. Data on inpatients in state, county and municipal institutions are expressed as rates per 100,000 population. Colors correspond to US region.

This would imply a delay in deinstitutionalization in states that resisted federal control most vigorously, most notably in the South.

It should be stressed that these mechanisms are not mutually exclusive. Considering what the expression of each should look like in the absence of the others simply helps to pose better

questions of observed trends. Let us now consider these observed patterns in the timing and trajectory of deinstitutionalization.

## **STATE PATTERNS**

Figure II-1 displays state rates of hospitalization in what the Public Health Service and later the NIMH called “Institutions for Mental Disease” run by states, counties and cities over the period of 1938 - 1990. Prior to 1954 city and county institutions were reported separately from those of states; in the data reported here the figures are combined. Not included are institutions for the mentally retarded or epileptics (which are listed separately by PHS/NIMH). The (digitized) post-1967 data are courtesy of Stephen Raphael. Excluded are the District of Columbia, Hawaii and Alaska — in the latter two cases because the data are incomplete before statehood. Figure 1 gives these inpatient data as a rate of hospitalization per 100,000 of the state’s civilian population (US Census).

Visual examination of the state data reveals a picture that, as expected, is broadly compatible with the welfare state thesis. That is, we see a secular decline across-the-board, beginning for many states as early as the 1950s. In many states, but not all, there appears to be a decisive point of acceleration.

There is a strong regional pattern to states' deinstitutionalization trajectories. This is hardly surprising given regional patterning in policy and spending generally (Sharkansky, 1968, Sharkansky and Hofferbert, 1969), the uneven historical development of state hospital systems (Grob, 1983), and the fact that states theoretically looked to their neighbors for models in mental health (US Senate, 1955), as in a range of other policy issues (Soule and Zylan, 1998). Also unsurprising, given our examination of relevant programs above— but strikingly given the focus of the literature since 1979: a significant number of states see an onset of deinstitutionalization before the Medicaid program was passed in 1965, as a hasty addition to new legislation providing for medical insurance for the aged in 1965.

The task here is to evaluate accounts of the state role in these deinstitutionalization trends. But a few points about what does not explain such patterns: they have little correspondence with states' party-political structures, for example on any of the measures developed by Jacob and Vines. There is also little correspondence between the administrative structures in which states Mental Health authorities were embedded, and their deinstitutionalization patterns. These patterns as they existed in the mid-1950s are shown in Figure II-2, below. States are grouped by the type of administrative structure, with colors of the deinstitutionalization curves corresponding to their region. This should making it apparent that while there is regional patterning to both states' trajectories and to administrative types, it would be hard to distinguish the two when it comes to the timing of deinstitutionalization.

### Administrative structures, c 1954

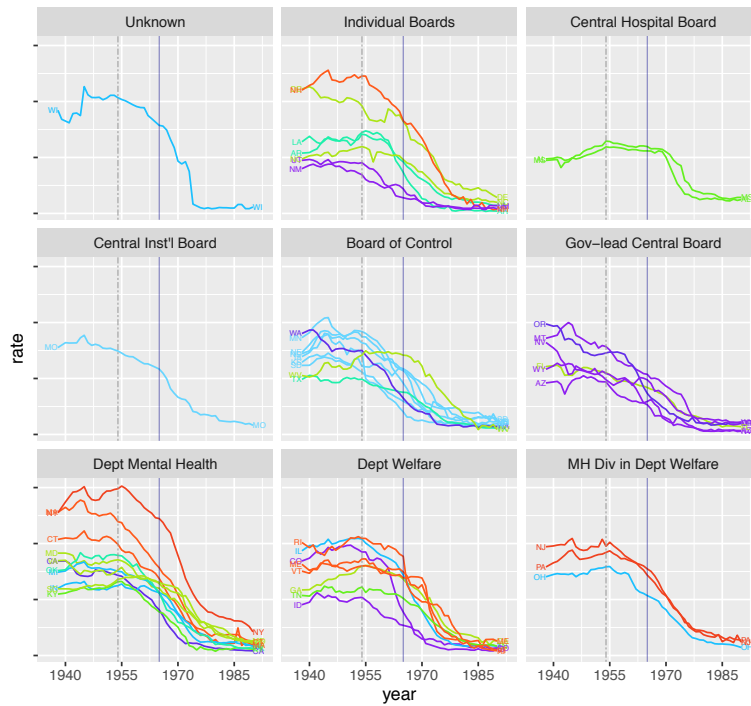
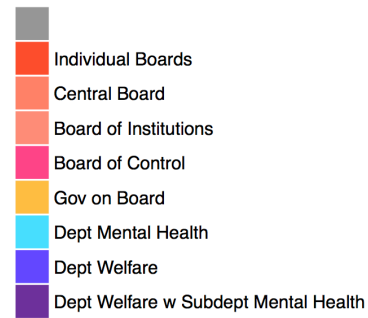
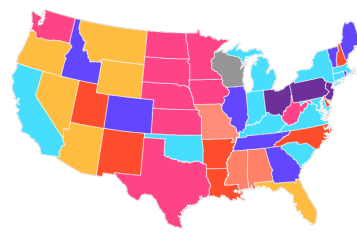


Figure II-2.

Top: state administrative systems for mental hospitals circa 1954 (data combined from Grob (1983) and Fuller (1954)).

Bottom: State trajectories of deinstitutionalization by administrative type c 1954; colors correspond to regions of the US.

The lack of an apparent pattern here should be a bit surprising for those who argue that states used federal grant in aid programs opportunistically to shift the costs of care for the mentally ill. They would have had to do so through, or with the cooperation of, a wide variety of agencies.

### **The onset of deinstitutionalization**

Is there any evidence that Rose is right about the onset of deinstitutionalization as fiscal policy? Very little.

The “fiscal crisis” theory does not appear plausible. Marked acceleration of inpatient declines simply occurs, when it occurs at all, where fiscal crisis did not. It happens in most states before the either the destabilization of state revenue bases, which scholars put around 1975 (Gamage, 2010), or the rise of a conservative anti-tax movement (Martin, 2008; Martin et al. 2009). Where the accelerations that might indicate a change in state policy occur, it is true that they tend to appear in the early 1970s. We will examine these cases presently.

If not of “crisis” per se, is there any evidence that states releasing mental patients early were poorer states? There is decisively not. If we focus on states that had already reduced mental hospital inpatient rates to below half of their peak rates in 1965, before the introduction of the



Great Society health programs, we can consider the early deinstitutionalizers to be Arkansas, California, Colorado, Iowa, Idaho, Kansas, Minnesota, New Mexico, Nevada, Oregon, Utah and Washington. These states, if anything, skew rich (Jacob and Vines, 1965; Sharkansky 1968b).

Let us look closely at two states in which deinstitutionalization happened early, that is, prior to 1965. California is typical of such states: western, wealthy, and with a pattern of gradual decline in its mental hospital population beginning in the 1950s.

In the scholarship on mental health policy, California has probably been best studied of any US state, first because it was considered so successful (see Marsh, 1963; Bradley, 1976), then because it wasn't (see Lerman, 1980, 1982; Segal and Aviram, 1978; Estes and Harrington, 1981). In the 1960s California is frequently cited, along with New York, and (less frequently) Vermont, Minnesota and Kansas as a pioneer in mental health. In the Short-Doyle program, instituted 1957, it had one of the early community mental health systems. By the mid 1960s, it was operating in 38 counties and had a caseload of about 33,000 — while the state hospital system had 30,193 inpatients. The Short-Doyle program was run through general hospitals, private clinics; the counties had the authority to contract for services, they sorted out the arrangements. Their efforts were aided by state matching funds on a generous formula (Marsh, 1963). In 1966 the state of California paid about \$23 million for the operation of the program, and \$11 million more was paid out by the counties; the same year the budget of the

state's Department of Mental Hygiene was \$111.5 million (Bardach, 1972). One observer remarks that, "it was commonly assumed" that the Short Doyle system served people, "of higher socioeconomic status and [with] less serious mental disorders," but while "these assumptions seem plausible" the administrators of such programs usually "sent the hardest cases to the state hospital system." Hence because the Short-Doyle served were outpatients, there was no way of knowing (Bardach, 1972, p. 25).

Our most valuable informant on the state's mental health policy is Eugene Bardach, a student of political science who cared little about mental illness or its treatment per se. Bardach was simply looking for a policy issue that would produce a case study of a manageable dissertation size when he set out to "map the contours of the attentive public," for mental health. The "low level of routine interest" produced by the Department of Mental Health's annual appropriation seemed to Bardach just the thing (1972, p. 27). It is thanks to him that we have incidental observations of this context —"Although mental health had few close friends in the legislature, neither did it have many dedicated enemies," (30), "Mental health programs were rather different from other legislative programs in the health education and welfare, area. Legislative interest in them was minimal, intermittent and unemotional," (p. 31) — of a type that available nowhere else. But in the event, Bardach winds up doing a study on political skill: his work reveals that during California's period of long, evenly declining rates of mental hospitalization, some of the state's lawmakers became involved in the drama of revising the involuntary commitment laws. Both the lawmakers and Bardach believed initially

that this was a long shot, but the former find bipartisan sponsorship for the reforms, win over the mental health professionals, and ultimately it is discovered that the courts don't really care about maintaining their control over mental hospitalization—and thus surprising everyone, in 1967 they win the repeal of involuntary commitment laws in the state of California (Bardach 1972, see especially chapter 4).

The election of Ronald Reagan as governor is often associated with California's deinstitutionalization. Bardach was there for that too. He describes this as a rare moment in the mainstream of public attention for the mental hospitals—so long ignored and uncontroversial in state politics—as they become a target during the gubernatorial campaign (p. 31), the immediacy of public outcry when the newly-elected Governor attempts to include

various cuts in the  
mental health funding

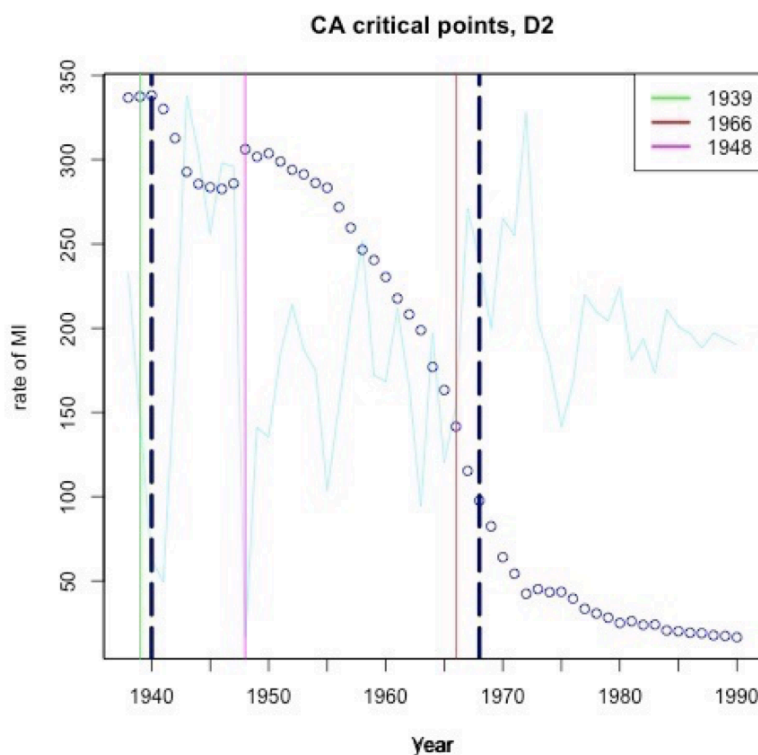


Figure II-3.

California's rates of mental hospitalization with critical points indicated.

Year of maximum inpatient rate is green, year of acceleration is in red, and onset of acceleration is in magenta. Blue dotted lines mark reorganizations in the administrative structure of the state's Mental Health authority, occurring both in 1940 and in 1970. The light blue line indicates the change in the acceleration trend.

in his first budget, and the eventual result— which is that the governor mostly backs down but still manages to effect some of the cuts—strictly to the operating budgets of public mental institutions and not to Short Doyle (p. 141-142).

*All* of these things happen over the period of 1966-1967. In fact, the data from California show that none of these events effected *any change at all* in the trends in rates of inpatient decline in California's mental hospital system, by then nearing the end of their long, even, gradually accelerating decline, which had begun in the 1950s. The pattern in California is a near-perfect approximation of what we would expect if the archetypical version of mechanism two above were playing out.

Iowa's pattern is atypical. It is the only state that shows a very marked acceleration in net patient declines before 1965. Whereas nearby Kansas, which also deinstitutionalized early, was the site of the famous experimental Menninger clinic, the stuff of Congressional lore in 1955 when the feasibility of a national mental health policy was first discussed (Grob 2014; US Senate, 1955), what happened in Iowa in the 1950s has been completely ignored in mental health policy scholarship— or almost. There exists one published article on Iowa's mental health system. In 1967, its Washington DC-based authors notice that the state has seen a 75% reduction in the inpatient populations in its state hospitals, note that there exists only one comparable mental hospital inpatient decline on record — Saskatchewan in the year of writing — and they go visit to try and find out what happened. In their story about how Iowa

“rang the bell for mental health as early as 1946,” making administrative rearrangements, and raising public awareness of the special plight of the afflicted group, there is nothing that would distinguish Iowa from any other state (Hammersley and Vosburgh, 1967).

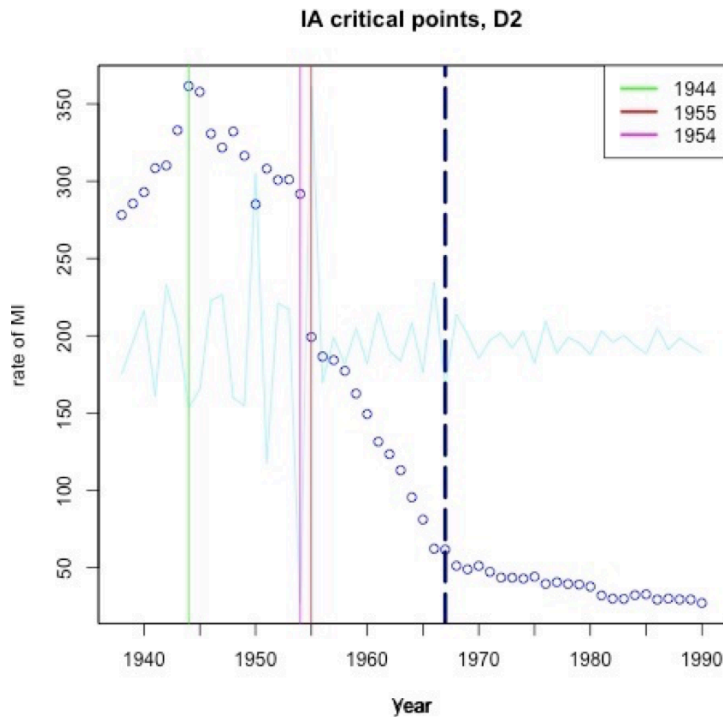


Figure II-4.

Iowa's rates of mental hospitalization with critical points indicated.

Year of maximum inpatient rate is green, year of acceleration is in red, and onset of acceleration is in magenta. Blue dotted lines marks a change in the administration of the state hospital system in 1967. The light blue line indicates the change in the acceleration trend.

However, the authors do give a fairly detailed account of what appears to have been a unique fiscal structure in Iowa: counties were required to pay the full costs for their residents' care in state hospitals up front. The existence of this exceptional payment system is affirmed by an administrative law review published in 1961, in a footnote. It states that Iowa's legal codes provide that, "Mentally ill persons and persons legally liable for their support shall remain liable for the support of such mentally ill [...] The county auditor [...] shall enforce the

obligation herein,” (Mernitz, 1961, p. 455). Practically, this system results in the state recuperating more than \$6.5 of its \$9 million mental health budget in 1966. It also appears to account for the “extensive system of county homes or ‘poor farms,’” first established in the 19th century, that in 1967 were caring for 6000 former state hospital patients. The farm operators are paid by county supervisors \$10-15 per head a week. They clarify to the visitors from DC that they don’t provide nursing care, and that they don’t want to be recognized “under medicare” [sic] because of its staffing requirements.

The article has no lessons to draw from Iowa’s success. “Combined efforts,” its baffled authors conclude, “of the many individuals who used the tools at hand—the fiscal responsibility of the counties, the interest of the county supervisors in the fate of their residents, and the Iowa tradition of do it yourself” together spelled the early success of deinstitutionalization in this state (Hammersley and Vosburgh, 1967).

To this sole account, it is worth adding one detail. In 1947 Iowa was running a 17% deficit. Hardly a wild outlier among other states at the time, it was the worst year for the state budget since 1929. By the early 1950s, the state’s finances appear to have righted themselves once again.<sup>5</sup> Iowa may afford the best evidence for Rose’s “fiscal crisis” thesis.

### ***Medicaid and patient dumping***

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<sup>5</sup> Data from Sharkansky (1968), Table III-8, p. 50.

If deliberate cost shifting on the part of states drove deinstitutionalization, then we should see precipitous declines following the introduction of federal programs that incentivized states to shift patients out of state institutions in order to transfer the costs of their care. Grant in aid programs did this— or at least that has long been the claim. The Senate Subcommittee so put out about the Kerr-Mills program, in fact, attributed the “frustration of congressional purposes” to just this mechanism (US Senate Subcommittee on Aging, 1963). The reason that grant in aid programs have so often occasioned scrutiny of dumping is, of course, the context of the special relationship they set up, described by Derthick and others, between the two states party: Grant in aid programs allow governments to claim monies from other governments with the promise that they will use it *only* for purposes defined by the latter. It also then easy to see how programs like Kerr-Mills and especially Medicaid might have facilitated state action to depopulate mental hospitals: they would have allowed states to claim money on behalf of their mental patients from the federal government, and with it pay other parties for their care.

This was the mechanism offered by Gronfein, whose study found a strong and highly significant correlation between a state’s Medicaid payments and the net discharge from its mental hospitals. As noted above, it is this examination alone must validate “dumping” as an account of states role in deinstitutionalization, since others make which make the argument do so without attending to trends across states. The logic of Gronfein’s design is that, “if Medicaid payments were differentially associated with inpatient decline, then states with

greater Medicaid involvement would show larger declines during the same period,” (Gronfein, 1985a, p. 201).

In fact if this were true, it would be quite surprising. There is no reason to doubt that Medicaid was “by far the largest single program of the fifty government programs providing nursing home aid,” (p. 201) in the 1970s, as Gronfein contends. This finding is stated in the GAO’s 1977 report, and has withstood much subsequent repetition. However Medicaid coverage was mandatory for all beneficiaries of federal income support programs—the program covered 23.5 million individuals nationally in 1975. Medicaid in other words affected many more people than the populations whose dumping Gronfein is concerned with.

From as early as the 1970s, a body of scholarship has been devoted to understanding state patterns in Medicaid implementation; some of this literature is oriented to explaining what predicates states’ spending under Title XIX (e.g. Davidson, 1978); other analysts highlighted major *qualitative* differences in states’ programs, and argued convincingly that dollars spent is a poor indication of what the programs actually do, for whom, and to what effect (Stuart 1972). Though payments to nursing homes seem hard to argue with as a possible indicator of states cost-shifting through Medicaid, it’s hardly clear why *aggregate* Medicaid involvement should necessarily capture states’ use of the program to transfer mental patients.

Serious questions also arise when we consider the historical window of Gronfein’s analysis. Title XIX became law in 1965 and states began receiving Medicaid payments as early as



1966. Why not begin the analysis with the start of the program? Gronfein writes only that “Medicaid data were available as early as 1970.” (Gronfein, 1985a, p. 201) The unanswered questions are clear from the rendering of the longer history of states’ inpatient rates as in Figure II-1: an analysis that focuses on exclusively the period of 1970-75 captures states at very different points in their DE trajectories.

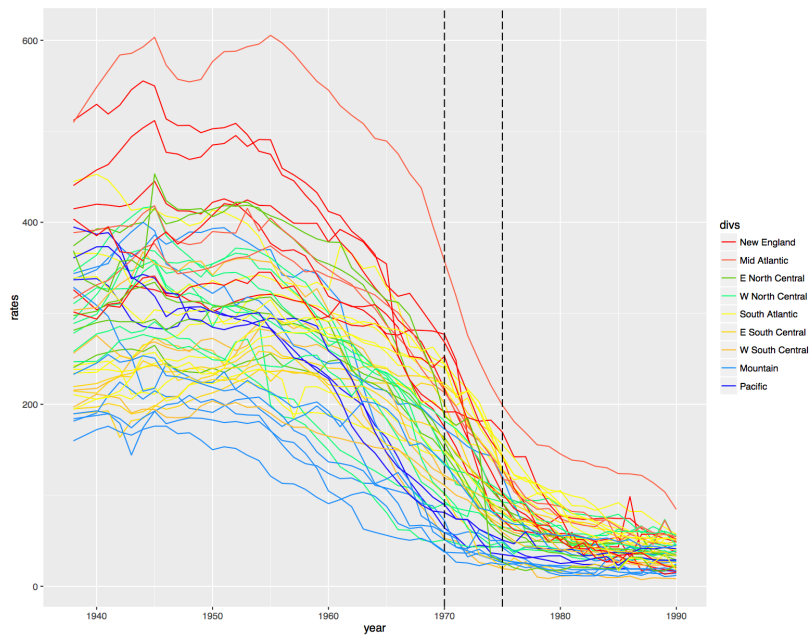


Figure II-5: States deinstitutionalization curves, colored by US region. The dotted lines indicate the period from 1970-1975, the period of Gronfein’s analysis.

There does exist one possible justification for focusing exclusively on the period of 1970-1975: only by this point did *all* states have Medicaid programs. The initial 1965 law

made instituting a Title XIX program a voluntary option for states. However, subsequent amendments to the Social Security Act mandated that all states begin operating Medicaid programs by 1970, or run the risk of losing federal funding for medical assistance entirely.

Some states began their programs in 1965; and as late as December 1968 ten states still did not have programs (Tax Foundation, 1968).

This is all relevant only to the extent that the Medicaid program represented a break with previously existing grants in aid for medical care. While federal funding for medical assistance had been available to states from at least 1950 outside of the Title XIX framework (see Table II-1 above), it was not offered on exactly the same terms. An analysis focused on the 1970-75 period, to be coherent, would thus need to be concerned in a strictly limited sense with role played by the incentive structure unique to Medicaid in driving state hospital inpatient rates downward — rather than the role of federal subsidies generally in deinstitutionalization. During this period and only then, such an argument might go, the effect of the Medicaid program specifically could be properly assessed because *all* states would be subject to it in equal measure. Such an argument would need to focus on the aspects of the Medicaid program to which states, in their patterns of deinstitutionalization, ought to be *differentially* responsive. The most obvious of these is the degree to which the federal government incentivized participation in the program with its formula for matching state funds.

The “federal matching formula,” compensated states for the provision of certain health services on a per beneficiary basis, anywhere from 50 to over 80 percent. Rates were set to inversely reflect a state’s tax base, such that poorer states were incentivized more heavily to participate. Whereas for wealthy states like California and New York, a dollar spent funding health services translated to a dollar of federal funding under Medicaid, for poorer states like Mississippi a state dollar brought about three dollars of federal Medicaid funding.

If this is the only coherent interpretation of the Gronfein study given the period of its focus, it is thus extremely strange that the author leaves it unclear whether his reported findings concern the relationship of state inpatient declines and the *total* amount spent under the program, or the federal dollars received by a state. At a minimum the omission leaves significant ambiguity as to what the finding of a relationship between “Medicaid involvement” and deinstitutionalization implies as to the mechanism by which the title XIX program influenced states’ behavior in mental health.

In order to settle these questions, it was necessary to replicate Gronfein’s analysis. The 1985 article cites volumes published by the National Center for Social Statistics as the source of its Medicaid spending data. These were obtained, and the relevant tables digitized. They contained aggregate data on payments to health care providers under Title XIX—that is, the total paid to medical service vendors out of each state’s federal “pooled fund.”<sup>6</sup> Relying on

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<sup>6</sup> The data are in fact those for medical vendor payments in the fourth quarter of fiscal years 1970-1975.

these figures, it was possible to calculate an approximate federal share of the Medicaid spending on vendor payments for each state, based on the federal government's per per-beneficiary reimbursement formula.<sup>7</sup> Both the total and the federal share figures were then correlated with a state's net inpatient declines from January 1, 1970 through the end of the calendar year 1975 (i.e., to January 1, 1976), with and without holding population constant.

Gronfein did in fact rely on the aggregate Medicaid spending. The Pearson coefficients obtained in this way match those reported in his article, with and without "controls" for state population respectively: .88 and .71 for Medicaid spending in general, and .92 and .82 for payments to "Skilled Nursing Facilities," with p-values showing significance in all cases. Surprisingly, he could have made his case stronger: when we rely on the approximated federal share, these correlation coefficients show slight *increases*.

A closer look at the data however quickly suggest the source of the surprising relationship that Gronfein reports between aggregate Medicaid spending and deinstitutionalization: The distributions are extremely skewed, with New York State a major outlier in both spending and discharges. Dropping New York from the analysis reduces the correlation to less than .2, without significance. Nonparametric correlations (Spearman and Kendall) yield no significance at all, regardless of the inclusion of New York (or California), or reliance on the

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<sup>7</sup> Diversity in state Medicaid programs mentioned above makes this only an approximation. The formula did not apply in the same way to the "medically indigent" that states included at their discretion, not covered under federal assistance programs. What I estimate is thus effectively the maximum federal share.

federal share or the total spending. The same indeed holds true for spending on Skilled Nursing Facilities: when methods for assessing less sensitive to outliers are applied, the correlations are reduced, and lose their significance.

However, the logical constraints developed to make sense of Gronfein's odd choice of period, suggest another way of interpreting state patterns in deinstitutionalization during the seventies. As noted, Medicaid was not the first federal grant in aid program to finance medical vendor payments. But as a federal program it was distinctive from its predecessors, both in that it was more generous to states, and that it conversely imposed stricter restrictions on how that funding could be spent. This is just what Derthick's work would lead us to expect. From this standpoint, it was the federal government's attempt to shape states' behavior as providers of medical assistance to the poor, that first allowed them to claim funds on the specific terms of the Medicaid program from 1966, and that in 1970 required that they do so. Thus, before 1970, Medicaid's uptake might *itself* be considered endogenous to the fiscal strategies in which deinstitutionalization figured.

States that resisted federal control through grants in aid more vigorously should thus deinstitutionalize later—that is, if indeed these programs allowed states to dump patients. This interpretation is suggested by the patterns of deinstitutionalization of southern states, disproportionate among those that do not deinstitutionalize until late. Data on the year and quarter of Medicaid's implementation reveal that indeed

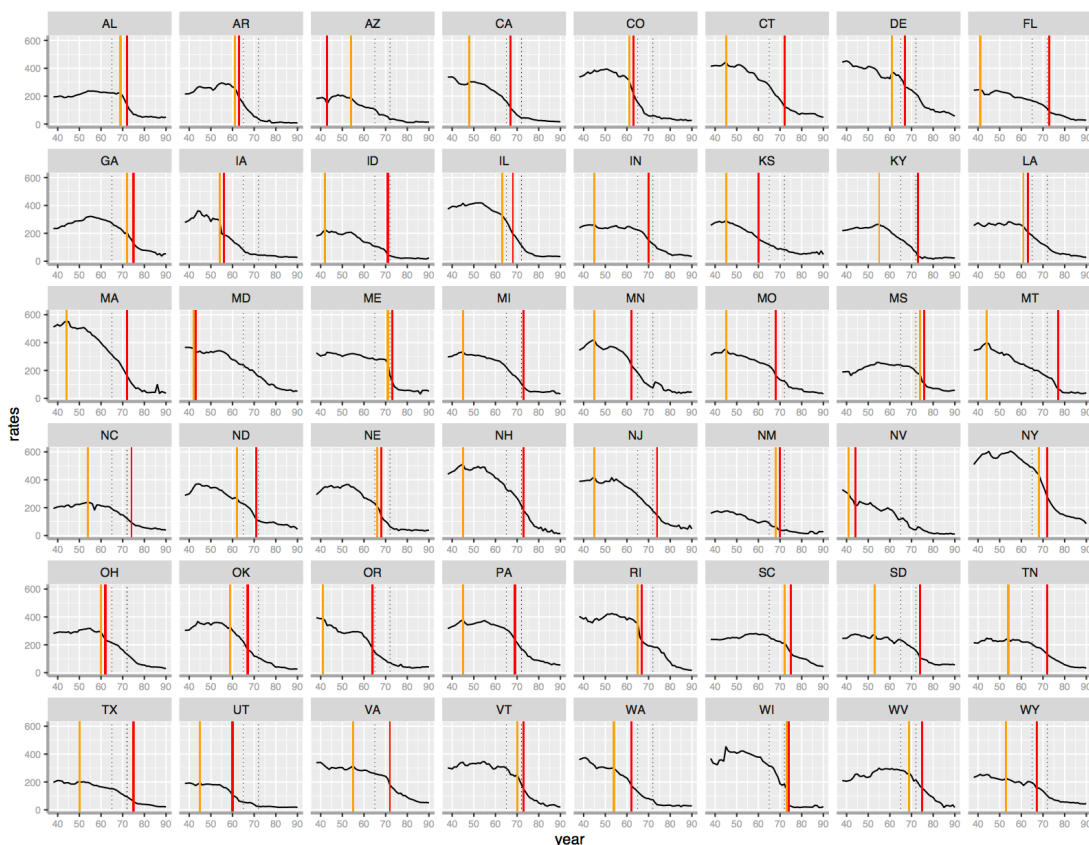


Figure II-6. Intensity of public mental hospital inpatient declines, by state. Deinstitutionalization's point of acceleration (red), and the point of onset of acceleration (yellow). (An early acceleration in Arizona that was not sustained puts the onset of its declines later. The state was also a rogue in Medicaid, in that it did not implement a program per federal mandate in 1970.)

Southern states did implement Medicaid programs later on the whole. Can Medicaid uptake then help explain the deinstitutionalization trajectories of states like Alabama, Mississippi, Virginia, and South Carolina—all of which see gradual deinstitutionalization, with a decisive point of acceleration in the 1970s? Data from the National Center for Social Statistics on total vendor payments from the federal government claimed by beneficiaries in a state are in fact available before the Title XIX program's uneven extension to all states. To assess the evidence

of the Medicaid program's influence I consulted the federal vendor payment figures, both to nursing homes, and intermediate care facilities (eligible Medicaid vendors as of 1973) from 1965-1975. This time series thus includes the federal government's vendor payments both before and after later states' Medicaid programs had been instituted.<sup>8</sup> I considered federal payment to each type of provider on its own, and as a proportion of total vendor payments on behalf of the state. When considering any of these measures, trends over time and across states are smooth: there is little sign that rates of federal payment to nursing home and intermediate care homes payments jumped following the late onset of Medicaid programs—either in the states of the former Confederacy, or anywhere else that it occurred. Colorado, New Jersey and Indiana all instituted Title XIX programs in or after 1968 as well. They did not use exploit the program to deinstitutionalize. Colorado already had done so, and both New Jersey and Indiana continued what they were doing—as far as falling rates of mental hospitalization are concerned.

There is in fact a more obvious account of the abrupt decline in states mental hospital inpatient populations in the early years of the 1970s: the introduction of the federal Supplemental Security Income program. SSI was an income maintenance program designed with the elderly in mind, but also extended to the disabled (Berkowitz and Dewitt 2004) not already in state custody. It was *not* a grant in aid program: the idea was for the federal government to assume responsibility for direct payments to beneficiaries of federal old age

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<sup>8</sup> To consider the role of the Medicaid program *specifically* in shaping states as action as custodians of the mentally ill, only these cases are relevant.

and disability assistance programs long administered by the states. Thus the Social Security Administration would pay all who qualified a single benefit, thus cutting out the states as intermediaries. Berkowitz and Dewitt, and—here again—both Rose and Clarke, among others, suggest that the program was key to the release of mental patients. It is easy to see how. The process of qualifying for disability, in both its medical and legal components, could be initiated while individuals were still in state institutions (Weddle, 1998). Once they successfully qualified to receive SSI, states paid nothing for it.

This would have been crucial to the states in the South, among others. In 1971 class action lawsuit directed at Alabama's mental hospital system had just resolved with a verdict in favor of the plaintiffs, mandating higher standards of care (*Wyatt v. Stickney*, 1971). Neighboring states' mental hospitalization rates had already substantially fallen. Southern states may indeed have resisted federal control through grants in aid, but here there was nothing here to resist: the federal government wasn't disbursing funds with conditions, it was simply going to give them out to individuals who qualified anyway.

Where the post-Medicaid patterns that most suggest "dumping" of mental patients appear, it is only after the Social Security Administration had begun negotiating with states about how exactly it would assume responsibility for direct income support payments to their elderly and disabled citizens (Derthick, 2011). There are some exceptions: In addition to Iowa, noted above, Rhode Island appears to have "dumped" patients in 1966. Policymakers in the state



had in fact spent the years following the introduction of the Kerr-Mills medical assistance program “studying” the development of a system of private nursing home care for elderly residents, which would be federally subsidized (Sharkansky, 1968a, Appendix 1). The state appears to have discharged the mentally ill en masse to this same system when the Medicaid program was introduced.

This analysis is no more than preliminary. But it does make one thing clear: the account of deinstitutionalization that emerged post-1979 and which focuses on the states’ role in dumping their mental hospital patients, has little basis. Such accounts seem to have borrowed evidence of the sort marshaled by Stephen Rose, while blunting his critique. As it happens, the evidence was faulty. In observed state patterns of deinstitutionalization, there is little to warrant the conclusion that states in general acted entrepreneurially, attempting to use federal dollars to discharge state hospital populations en masse. Or there is at least as much to warrant an alternative interpretation of the role of state government: states got out of the way, making room for a market in mental patient care to expand.

## **CONCLUSION**

Stephen Rose won the argument with Gary Clarke over deinstitutionalization, while getting almost none of the historical details right. Clarke on the other hand was right about most of what he argued: There is little evidence linking the onset of states' reduction of their mental hospital populations to fiscal pressures when it comes to the onset of deinstitutionalization nationally. Nor is there much basis for the claim that states seized on the Medicaid program introduced by the 1965 amendments to the Social Security Act specifically, in a concerted attempt to empty public institutions. The timing of acceleration in a number of states' discharge patterns makes the influence of the federally administered SSI program, initiated in the 1970s, more plausible as a trigger of deinstitutionalization.

By that time, “dumping” was not only made as fiscally attractive by the new income-maintenance program for the disabled, postwar federal policy in the health field would have had a chance to create a healthcare marketplace with needs of its own. In the literature on deinstitutionalization it is a commonplace that the federal Community Mental Health Centers program “didn’t work” as the transformative force that its champions had promised. Given the lack of evidence for patient dumping, it is worth considering an alternative possibility: namely, that as an early driver that in fact, CMHCs were effective contributors to the process that in fact drove the depopulating state mental hospitals. In many cases their operations would have contributed to the expansion of the private market in mental health care.

The claims of these new market actors were ones that states, starting from the mid-1970 were ever more poorly positioned to resist. Following the 1973 recession, state budgets *did* come under a kind of pressure unprecedented since World War II (Gamage, 2010). At that point, a politics that would favor public shedding of social responsibilities in the name of fiscal responsibility was still yet to emerge.

Who was Gary Clarke? Possibly he was on the *avant garde* of the new fiscal austerity, currying favor with policymakers who would soon need arguments to justify their actions. Or he may have been the simply concerned wonk he presents on paper, who, with his deep familiarity with state mental health policy, got the facts right and the big picture wrong. His published biography is slim. He left the Intergovernmental Health Policy Center and went to a job as director of Florida's Medicaid program from 1988 to 1994. There he was instrumental in the program's 1992 reform. In 2009, he sat on the board of WellCare Inc, a publicly traded "provider of managed care services exclusively through government-sponsored health care systems" when it was sued by the Justice Department. Accused of inflating reported costs of its behavioral health services to "avoid returning money to Medicaid and other programs in various states," the company settled the same year, for \$137.5 million.

### CHAPTER THREE: IDENTIFYING CONTINUOUS CONTEXTS

How did contemporary art—a relatively esoteric corner of cultural production— become, in the US of the late 1980s, a subject of political contention that ultimately issued in drastic cuts to public funding for the arts and humanities? In what sense has the understanding of the tasks of governance evolved over the course of the country’s history? Does the tone of economic coverage in the media affect investment on the part of firms and governments--has this changed over the past century, and if so how and when?

The continuity of language as a cultural medium makes it a plausible source of evidence of persistence and change in the social world. Automated text analysis today promises to reanimate social scientific inquiry into sociocultural phenomena over long periods of time, in that at best it permits us to approach such evidence with disciplined methods of abstraction -- thus promising answers to the sorts of questions posed above (respectively by DiMaggio et al., 2013; Rule et al., 2015; and Barbèra et al., 2016).

But before we can consider what new computational techniques we might use to approach substantive questions in historical social science, we must confront a problem has gone largely ignored. Our approaches to compiling collections of text *to which to apply* any such technique all are wholly inadequate. Identifying documents that contain a particular search term — “arts funding” or “governance” or “economy” or whatever— will not, of course, yield

collections of documents suitable for approaching the questions above. To rely on them would mean committing a particular kind of teleological fallacy: It would involve misattributing a significance that the objects of our interest only *acquired* at some (unknown) point during the transformation under study.

A more complex example: The middle decades of the twentieth century saw an effort to reduce reliance on the country's extensive system of public mental hospitals. In fact, the movement for psychiatric deinstitutionalization succeeded — faster than anyone anticipated. And yet in the early 1980s, deinstitutionalization was widely repudiated as having represented an abdication of public responsibility for the mentally ill. Was the failure of the movement a tragedy or a farce? Understanding collective action here depends not just on knowing the path taken, but on uncovering what alternative possibilities presented themselves. Newspaper coverage might appear to offer a historically granular basis on which to reconstruct such possibilities—for example, to understand when and for how long plausible targets existed, around which the movement could have reconstituted its aims and base of support.

A search for “mental hospital” in *The New York Times*, here again illustrates the difficulties with what has to date been the standard method of composing textual corpora. Figure III-1 below shows the count of the paper's ledes containing the term, over pooled five year periods. For one thing, the number of ledes containing the term averages somewhere around 10 per year—hardly enough data to warrant computational treatment.

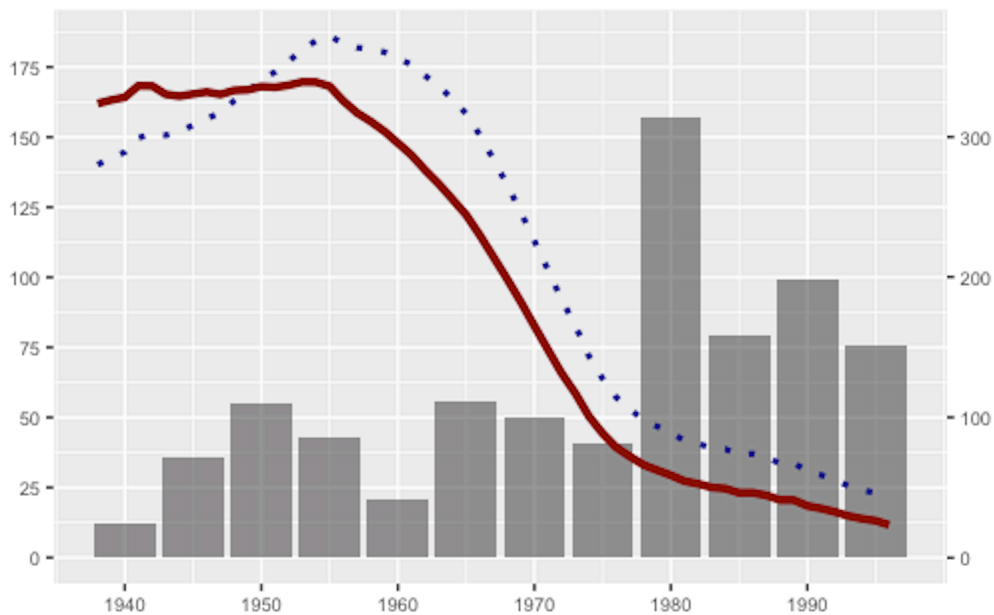


Figure III-1. Mental hospital inpatients nationally and the frequency of the term “mental hospital” in *New York Times*, 1940-1995. Bars represent number of ledes published by *The New York Times* containing the term “mental hospital” (pooled over five year periods, scale on left), lines are inpatient populations in public mental institutions in the US (scale right represents rates per 100,000, in red).

Further, at the historical moment that state psychiatric hospitals were decisively depopulated, and eclipsed the central feature of a mental illness treatment system, the frequency of occurrence of the term “mental hospital” in the *New York Times* explodes. A look into the paper’s coverage reveals that many instances of the term occur in the context of discussion of John Hinckley Jr., who attempted in 1981 to assassinate President Ronald Reagan, eventually acquitted of criminal charges by reason of insanity.

The words used to refer to particular socio-cultural objects of interest change over time, making them poor instruments to study the evolving significance of the latter through text. But the mental hospital example suggests that in many, perhaps most, cases that concern social scientists, the central challenge in identifying documents is different: it is to recapture the social context in which the objects of our interest are relevant continuously over time.

Computational social scientists are just beginning to recognize that the selection of documents for analysis is problematic. As King and colleagues recently put it, reliance on keyword search means that “the most sophisticated analysis techniques depend in practice on ad hoc methods they were designed to replace” (King, Lam and Roberts, 2017: 1). Recent work has shown that empirically, “decisions about how to select a corpus matter a great deal” (Barbèra et al., 2016). Both groups of researchers offer practical suggestions to improve on word-search methods for collecting documents in particular research settings. But broadly satisfying ways of approaching the problem of document selection have not yet been offered.

In the following Chapter we offer two contributions toward this goal; one methodological, the other theoretical. First, we develop a flexible tool for compiling collections of newspaper coverage that capture a given social context over long periods of history. We model word patterns of word co-occurrence in ledes published by *The New York Times* over the last century, locating reported events an abstract space that reflects the changing organization of the social world. We design a way for researchers to interact with this model, relying on their

knowledge of the objects of their interest in a specific period, in order to compile collections of documents that span many decades.

Second, we propose a way of conceptualizing just what about these document collections is consistent—what makes them suitable candidates for analysis, automated or otherwise. A standpoint is a framework for ascribing meaning. It provides an analytic tool with which social scientists can approach document selection and the variety of other decisions necessary to create, from collections of text, descriptions of the world seen by others.

The Chapter is organized as follows: We first situate the task of selecting collections of documents as a methodological problem for historical social science. Next, we explain our strategy for approaching it. We collect about 12.4 million *New York Times* ledes, representing every event covered by the paper from 1900 to 2015. We use a neural embedding technique to organize these documents on the basis of word co-occurrence. The model renders paragraphs as vectors—locations in an abstract “space” of 100 dimensions. We train local models over successive five year periods of Times coverage, and align these to approximate a dynamic model, which evolves over the 115 year period.

We conclude by outlining a protocol for researchers to interact with the model. By choosing a period of focus, a researcher can define a “context” of related coverage during an historical period with which they are familiar.



In next Chapter we evaluate our document selection technique. We present a way to do this which, like the techniques developed by computer scientists, stages a truly risky test—one whose outcomes are not affected by the researcher’s prior familiarity with the material under consideration. The test does not, however, depend on the untenable assumption that the evaluator lacks a standpoint for her choices.

## MOTIVATION

The problem of historical social research is to *orient* the object—event, activity—of interest in the distant social world of which it is part, in the hopes of imputing motives of the events’ protagonists. Attempts to impute motives to historical actors have often taken quite canonical forms. Often they begin with general theories of action, in the case of historical social scientists. Historians start with other historical accounts of the period.

Consider the rare contrast of E. P. Thompson’s inquiry into the origins of the Black Act, an unusually punitive set of criminal laws directed against poachers, in early 18th century England. To learn more about the activity—“Blacking”—that elicited this unusual response, Thompson *begins* his research with manuscript sources written by contemporary observers.

This approach makes the historian, as he puts it, “like a parachutist coming down into unknown territory: at first knowing only a few yards of land around me, and gradually extending my explorations in each direction” (1975, 16). This image of the researcher groping around, trying to understand what appears in front of him as part of a landscape, is Thompson’s metaphor for what it is like to rely on contemporary texts to orient oneself to the setting for one’s subjects’ action, “as they themselves saw it” (17).

It is notable that Thompson manages to orient himself although almost none of the hundreds of texts on which he relies to do so are written by his subjects themselves. “The Blacks left no manifesto, no articulate apologia; not even a substantial deposition survives from which we can recover their case. Hence it proves all the more necessary,” Thompson writes, “that we place them in *the most complete context, so that from this context and their actions we can deduce something of their motives*” (1975: 53; italics added).

How is this achieved? Through the writing of their contemporaries, Thompson pieces together the things of the Blacks’ world. In the documents on which he relies, the historian identifies recognizable objects that would have been relevant in the lives of the people living in the sites where Blacking took place, like Windsor forest. Deer, for example, figure continuously in the concerns of the English royal officers, and Thompson is eventually able to infer “an ancient enmity between democracy and these gentle creatures” (56). He thus is

eventually able to understand them as targets of the Blacks' campaign of attack, which was, he infers, "retributive in character and less concerned with venison as such than with the deer as symbols (and agents) of an authority which threatened their economy, their crops, and their customary agrarian rights." (1975: 64)

The unfortunate deer are, of course, only one element of the setting in which those customary rights had been exercised, and were threatened. It is a setting Thompson discovers bit by bit, through written references to peat, tall hedges, fish ponds, confiscated dogs and blunderbusses, and on and on—objects interlinked in system of social relations. Both the relations and the objects figure in the writings of the time, the former both as part of the picture, and as Thompson's basis for interpreting the way the latter appear—that is to say, the way they are rendered in text. And so Thompson reconstructs the Blacks' world, as an array of related things—through the words of others. Put differently, what the historian achieves is similar to what the ethnographer Clifford Geertz calls an "actor-oriented description" of the situation in which Blacking made sense.

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In most cases that concern social scientists, the problem of collecting relevant documents for automated text analysis is none other than a particular version of the one described above. Namely, it a part — the first and most challenging part — of the task of reconstructing a relevant social context, thus achieving a standpoint from which to interpret some collective activity of interest.

Automated analysis of text promises a new set of tools for crafting actor-oriented descriptions of the worlds of the past—settings whose native informants are long gone, where material artifacts are lost to observation. But the major difficulty, so far largely unrecognized, is that to do so, such methods must presume a set of documents that can be said to represent the point of view they aim to reveal—and in the case of longitudinal collections, to represent it *continuously* over long periods of time. It is the latter that is our concern here.

How do we identify such collections of documents? On one hand, as Thompson’s study of the Blacks helps to clarify, we need not depend on texts that were actually *produced* by the actors of interest. “The Blacks left no manifesto,” Thompson writes, nor does anyone know for sure who these premodern activists were. But even if these individuals had produced writing about their lives, it is hardly clear that it would necessarily illuminate why certain of the denizens of Windsor Forest *became* Blacks, hustled the forest officers and attacked the forest deer (1975, p. 53). For historians and historical social scientists, actors themselves are problematic. The reconstruction of a public world is required to account for their appearance and dissolution, their power and their quiescence, as often as the other way around.

On the other hand, the problem clearly goes beyond simply identifying “contemporary” textual sources. Compounding the difficulty, in compiling a collection of documents suitable for historical research, is an irony recognized by Max Weber more than 100 years ago. Events

of historical interest are inevitably defined as such by the researcher. This implies not only that the scholar's concerns *motivate* the inquiry (Zaret, 1980). Weber's point is that very objects of investigation are necessarily ones *recognizable to* the researcher—that is, from a position in history contemporaries could not have occupied! Conversely, to paraphrase Arthur Danto, most of what matters to people at any given point is insignificant to their eventual historians (Danto, 1985, see especially chapter 7).

For Weber of course what others are up to is only ever known imperfectly, “adequately,” at the level of meaning. The significance of particular acts, events, objects in the minds of people is inevitably constructed, something which the public, intersubjective nature of meanings makes possible. In what follows we make no strong claims about these inevitably constructed ways of ascribing meaning. But we do give them a name: they are *standpoints*.

Even given Weber's understanding of the limits *inevitably* involved in reconstructing what is meaningful to others, historically distant standpoints are somehow different. Social developments that occur in between the time of the action under study, and the researcher's own point in history, introduce new senses of significance to the world (Bearman et al, 1999; Danto, 1964). If there is a sense in which the growth of capitalism has made the practices of the early Calvinists available to us today, it has also made the world they operated in unrecognizable “as they saw it.”

Weber's antipostivism thus raises major questions about the analysis of social contexts over long periods of time. That is, if Weber thinks that the researcher inevitably constructs the action of the past on the basis of contemporary interest, what of our ability to identify a context continuously, as its appearance changes? This of course is required, if we are to understand social action organized on larger scales (Abbott 191: 225). The problem with the changing "appearance" of the world is of course that the change must be relevant to contemporaries, not rather than the historian. The sense in which retrospect inevitably bleeds into any description from a retrospective standpoint, coloring (only) the objects one is capable of finding, thus raises serious doubt as to whether it is possible to "case" or periodize an event that unfolds over the historic *longue duree*. Doing so requires a standpoint other than our own (Bearman et al., 1999).

Practically speaking this has not generally been a problem. Historical studies take a long time. Models of history that describe context as richly as Thompson's are extremely rare. Sewell, writing twenty years later, finds it necessary to point out to his fellow historians a Geertz-type approach to material culture is *possible*. Interestingly he also points out that a Geertzian understanding of distant worlds as symbolic "systems" is synchronic only *analytically*; but he doesn't even consider the possibility that such accounts could move through time (Sewell 1998). The study of the Blacks focuses on about five years, between when the Blacking started and the Laws were passed. Careful reconstruction of context, in the style of *Whigs and Hunters* is has rarely been undertaken over longer periods.

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To sum up: Weber's remarks on the partiality with which social scientists approach the past are intended to clarify the dilemmas particular to historical research. The challenge for historical researchers is not to identify what is most salient to people of other epochs, but to orient *our* interests in *their* world.

The corresponding methodological problem in selecting document collections is thus quite delicate: it involves distinguishing the masses of irrelevant text that define the historical record of any given moment, from those that contemporaries would have read as related to the research concern. Here we propose that the ability to do so at one historical moment, gets us closer to achieving a continuous standpoint on the world as well. The continuity of language as a medium then enables us to move through history, relying on objects were not originally our own.

Below we develop an approach to document selection that is sensitive to the problem of asymmetrical standpoint that Weber describes. The type of setting with which our approach is concerned is somewhat different from that of Thompson's subjects. In preindustrial England, as the Blacks became an issue of concern in London, they themselves would have had limited ability to situate the political actors so concerned with them. In Windsor forest news still

came largely through fortuitous social interactions. Our method, by contrast, applies in a complex, modern world, of which second-order representations reach actors daily.

By modeling the language used in such settings to represent publicly significant events—newspaper coverage—we can organize documents so they reflect the organization of the visible social world as it evolves. The researcher’s knowledge of her own interests at a particular point in history serve in navigating our model of the world at that moment, so as to identify the relevant social context, as a collection of reported events. Based on a collection of document representing what would appear to contemporaries as a coherent context, can propagate that collection. That is, we can move across history, compiling past and future events that constitute the *same context*, based on the way contemporaries use language. Doing so allows us to achieve document collections that reflect a consistent standpoints as the historical context changes.

## **DATA**

Social scientists pursuing a range research agendas have relied on newspaper coverage as a window onto past events (Fransozi, 1993; Paige, 1975; Schrod, 1994; Silver, 2003, among others). Newspapers of course do not report all events, nor do they necessarily report them accurately or without bias (Molotch and Lester, 1974). Responding to criticisms made on this



basis, researchers who depend on newspaper coverage have pointed that it often turns out to be the original source of other “primary” documentation (Fransozi, 1987). Indeed researchers are in a position similar to that of most contemporary readers: for most, these textual accounts constitute their only access the events described.

For our purposes here, the extent to which newspaper articles provide a transparent window onto events described is largely irrelevant. We are less concerned with the unique reported event than in the picture of social reality that arises from newspaper coverage, through the regularities in the way events rendered in text, “occur.” Our only assumption is that to whatever extent newspapers do distort events, they do so *systematically* over time— just as critics have in fact argued (see Fransozi 1987 for review).

We collected coverage of every event reported in *The New York Times*, from the beginning of the twentieth century to present, 1900-2015. Rather than the full text of each article, we rely on the so-called “abstracts” of all articles published by the paper, which are freely available through the *Times* API. These generally consist in the headline and first sentence or two of the article— that is, the “lede.” During the one hundred and fifteen year window, the *Times* reported on more than 12 million unique events. Our database thus includes some 12.4 million documents, comprising about 25.9 million sentences and 535.7 million words.

To be clear, *all* events that attracted *New York Times* coverage are represented in the database, irrespective of the kind of event reported, or the section of the paper in which they appeared. Artistic events—in the form of reviews of books and performances, scientific findings, cultural trend reporting, the performance of the stock market—all are included. The database thus reflects the universe of events visible to a paper that sees itself as covering, “All The News That’s Fit to Print.” On a given day it is doubtful that the average newspaper consumer reads articles corresponding to more than a fraction of the articles whose ledes are included in the database. However, our aim at this stage is to compile a collection of documents that define the set of *possible* public perceptions of the social world at a given historical moment.

Represented in the data are of course major historic events as they were perceived at the time of their occurrence— 9-11, the bombing of Pearl Harbor, the Armistice:

*WAR ENDS AT 6 O'CLOCK THIS MORNING; The State Department in Washington Made the Announcement at 2:45 o'clock. ARMISTICE WAS SIGNED IN FRANCE AT MIDNIGHT Terms include Withdrawal from Alsace-Lorraine, Disarming and Demobilization of Army and Navy, and Occupation of Strategic Naval and Military Points.*

The database also, of course, includes events whose significance was ephemeral, including routine events like sports matches, elections, box office records, deaths. “*Duke Kahanamoku in Hospital,*” reads one lede published in 1966, referring to Olympic swim champion, character actor and popularizer of surfing, whose native Hawaii had only recently become a US state. In point of fact Kahanamoku lived two more years, dying at home of a heart attack in 1968. Some events turn out to be non-events.

What is crucial about the language of the documents included in the database, for present purposes, is that it expressed events' significance succinctly to readers at the time of publication. *New York Times* ledes share the literary qualities that scholarship has identified in headlines generally. They lean heavily on metonymy and anaphora— they refer “back” to objects and situations at least implicitly previously defined (e.g.: “The Crisis”, “The Attacks,” [Mouillaud and Tétu, 1989: 120; Charaudeau 1997: 249]). References to the “Surgeon General”, or the New York Health Commissioner as “Comr Hillboe”, “suppose not only a certain minimum of political and general knowledge, but also help to situate the readers”, in this case, by defining the either the US or the New York State as the shared political standpoint (Develotte and Rechniewski, 2001: 1).

To communicate economically, ledes rely on the symbolic forms of the readership's shared world—images, institutions, behaviors— the things that contemporaries, per Geertz, “perceive ‘with’ or ‘by means of’ or through” (Geertz, 1974). This style of writing is highly codified, and historically uniform. In the aggregate, patterns of language use should thus be responsive to change in the right way: they should reflect changes in organization of the newsworthy world.

## **METHOD**

Events concatenate over time, giving rise to structure. Whether, and in what sense, this may be true of the social world “in itself” is not a debate we engage here. But we do assume that is true of the representation of the world afforded by newspaper coverage.

The distinctively modern type of reality that daily papers evoke, so familiar as to be invisible, is described beautifully by Benedict Anderson. Within the “homogenous, empty time,” of regular publication, Anderson writes, “‘The world’ ambles sturdily ahead. [...] If Mali disappears from the pages of *The New York Times* after two days of famine reportage, for months on end, readers do not for a moment imagine that Mali has disappeared, or that famine has wiped out all its citizens. [...] Somewhere out there the ‘character’ Mali moves along quietly, awaiting its next reappearance in the plot” (Anderson 1983: 33).

Our modeling approach approximates what Anderson’s study reveals newspaper readers do spontaneously. We abolish time analytically, just as Sewell says, to form a picture of how social reality is organized (1998)— in relation to which we can, in turn, recognize the contemporary relevance of particular events.

We rely on a neural language embedding technique to model word co-occurrence patterns in *New York Times* ledes as a 200 dimensional “space.” The model assumes a complex world. It allows us not only to position reported events, but to consider their relationship to one another

from a variety of standpoints. Newspaper readers, of course, keep their picture up-to-date, assimilating changes in the world's organization as they occur. And that is on the same basis that we track patterns in significant events continuously, over the 115 year period of *Times* coverage described above.

In the section that follows (“MODEL”), we describe the model. We use the *Times* coverage to train word embeddings over five year periods, and align these so that they represent a continuously evolving “space.” In the context of this Chapter we do not go into great detail on the training, and none on the alignment process. We do introduce Word Embeddings generally, and the formal innovation represented by our use of them here. The approach we develop makes assumptions not just about the relationship between specific texts as vectors, but about the distribution of vectors across regions of the model's abstract space. We explain the hypotheses that guide our attention to the relative density of paragraph vectors representing *Times* coverage. Relying on these hypotheses we can navigate toward what is *relevant* to contemporaries.

We then explain how the model can be used as a research tool. We develop a protocol for researchers to approach document selection with Weber's historiographic dilemma in view: We design a way to interact with the embedding space, so an expert in a particular period may use it to locate an object of interest in its relevant social context. The technique that we propose relies on what is plausible in keyword-based approaches to document collection for

social scientists: we can identify some of the words that would appear in some of the documents of interest, some of the time. The times it can, we posit, are limited to the set of historical periods in which we know something about a context already, as it appeared in print. The following section (“SEEDING”) describes the protocol that researchers may use to describe region of related ledes within the embedding space of a given period, thus representing a social context relevant to contemporaries.

Our dynamic embedding model then allows us to propagate the collection of documents that the researcher has selected, to achieve a consistent standpoint on the context of their interest over time. Such collections capture the way contexts apparent in the news to contemporaries evolve—continuously—based on contemporary language use. However: they need not be continuous *in the same way*.

In the final section (“PROPAGATION”) we propose several strategies for propagating the seed across the dynamic model, so as to compile collections of articles that reflect one of several consistent standpoints on a changing social world. Though social scientists have little vocabulary for continuity (Patterson, 2004), we propose some ways of thinking about what these collections might capture. In Chapter Five we will have a chance to consider the forms of description that each collection yields when abstracted.

## THE MODEL

To organize *Times* ledes, we rely on a word embedding model. For a given document collection, word embedding algorithms produce representations of each a given textual unit — eg a word— that capture that unit’s co-occurrence “context” in a reduced vectorial space. It is thus is just one of a range of ways of representing words as a vectors of identifiers, like other words or terms. We rely for our modeling framework on the Word2Vec algorithm, developed by Mikolov (Mikolov et al., 2013). Here, vectors are obtained by training a neural network architecture that predicts a word on the basis of its co-occurring words. In our model each text exists as a point in a geometrically defined space, that captures the context represented in *The New York Times* over a given period of time.

### *Doc2Vec*

We are not however solely concerned with words, but with events. That is, we want a model not of the meaning of words to contemporaries, but of the meaning of ledes. To achieve this, we rely on an extension of the original Mikolov (2013) model, Paragraph Vectors (Le and Mikolov 2014), implemented as Doc2vec. With Doc2vec the model of words is enhanced with information about longer units of text: sentences, paragraphs or documents — in our case, of course, the first few sentences on events reported in the *Times*.

There are other approaches to leveraging the word embedding framework to model documents. The most common way of assimilating multi-word texts to such models has been to model word embeddings and then to treating each document as the centroid of its constituent words' vectors (see Dai and Olah, for review). So positioned in a word embedding space, documents can then theoretically be compared with one another. Other approaches to assessing two documents' relatedness have included treating documents as the embedding similarity of all pairs of constituent words (Nalisnick et al., 2016), and using a pre-trained embedding model to calculate the number of moves between adjacent words would be required to transform one document into another (Kusner et al., 2015).

Doc2vec has several advantages in relation to these strategies, in that it takes into account the co-occurrence contexts of the paragraph, rather than just the words that appear within it, per the most common alternative approach of averaging word vectors. This is important for our purposes, in that the “document” is in the model *not* reduced to the collection of the words it contains. We are not interested in documents at all, but in events— specifically, a set of events that would together, for contemporaries, represent some part of the publicly available social world.

### ***Applications of word embeddings***

Research into the application of neural word embeddings thus far has most often focused on the properties of vectors representing unique words or documents. Conceptual relationships



between words may be examined through vector arithmetic (see eg Schmidt). Diaz et al. note that “in general, WEM approaches provide global representations of words; each word has a fixed representation, regardless of any discourse context.” Diaz et al. go on to explore the use of embeddings for specific discourse contexts that they characterize as topics; they do not explicitly consider historical contexts (Diaz et al., 2015). Indeed comparatively little work has deployed neural word embeddings to capture change over time. The major exception is in computational work on “lexical shift”, (Kulkarni et al., 2015; Hamilton et al 2016, 2017) which has demonstrated that neural embeddings can track transformations of the meaning of particular terms historically. Work on lexical shift has, per the general tendency of work on word embeddings, been focused on conceptually independent shifts of individual words, whether assessed individually or in the aggregate.

Experiments with Paragraph Vectors to date have focused analogously on relationships between particular documents: Experiments have shown that given a particular article, paragraph embeddings perform well in identifying the “most related articles” in collections like arXiv and Wikipedia, using nearest neighbors in the embedding space (Dai, Olah and Le, 2015). Duplicate entries in Stack Exchange forums can be found in a similar manner (Lau and Baldwin, 2016); and interesting relationships between articles can be uncovered—identifying, for example, the wikipedia article about the Japanese equivalent of Britney Spears — again relying on vector arithmetic (Dai, Olah and Le 2015).

Our focus is different. We are less interested in the properties of unique vectors or the relations between them— the primary concern of much of the previous work cited above— than we are in the properties of *regions* of the model space. The hypotheses that guide our approach relate to (a) the distribution of paragraph vectors in the embedding space, and (b) the relationship between dense subspaces, in adjacent historical periods’ models.

### ***Model assumptions***

We base our approach on the idea, for a model trained on *New York Times* ledes of a particular period, that the organization of paragraphs vectors should reflect an isomorphic transformation of the social world represented in the paper’s coverage.

A major theme of the work on neural embeddings cited above is that these models should place “semantically similar” words and documents relatively closer together (following the original framing of Le and Mikolov, 2013). Applied work that locates words and paragraphs in relation to one another on particular trained and pre-trained models provides evidence for this. Knowing what we do about the language of *Times* ledes — namely, that it is succinctly referential from a contemporary standpoint; that its style is relatively codified, invariant to subject matter and to history— we can specify the sense of “relatedness” that we expect to be captured by a model trained on our data. Two paragraphs should be “related” in as much as they evoke for contemporaries the similar *organizational* structures that order the way significant events occur. We expect patterns of co-occurring words, that is, to reflect the

institutional categories that organize the world the *Times* covers. Ledes that evoke the similar domains of social life should reflect these similar co-occurrence patterns—and these should be “pushed” together in the model.

Such an assumption has implications for the distribution of documents over the space. Assume that paragraphs representing routine events are relatively densely surrounded by vectors representing other routine events arising in the same organizational context—different ball games, different congressional elections, coverage of different fluctuations of the stock market, etc. Extrapolating this principle -- that some reported events are more routinized and predictable than others -- the distribution of paragraph vectors should thus be uneven over regions of the model space. We infer that “holes” in the model space—regions of relative sparsity in paragraph vectors—should index salient institutional *distinctions*, for instance between international and the domestic, political and economic, Wall Street and Main Street, literary and popular. Finally, dense subspaces on the model should comprise collections of events that relate to institutionalized domains of social life; the more institutionalized, the denser the clustering. As the examples indicate, we can characterize the space in this same way, regardless of scale— we expect domains to be fractal, with sub-clusters representing different

### ***The dynamic model***

The two steps of our modeling process are as follows.

[A] We pool *New York Times* ledes over delimited contiguous time periods, and train an embedding model for each. We thus achieve a series of static models, for each five year period of the *Times* coverage. As Sewell helped to see, Thompson’s careful reconstruction of the context of Blacking is synchronic analytically in just this sense. In considering the length of time over which to pool events, we thus follow his example of five years. We refer to each of these synchronic models as “Period” models.

[B] To create the “dynamic” model we align the period models with one another. The process of generating word embeddings using doc2vec is stochastic. Though two different models trained on the same corpus and vocabulary should capture the same relationships between words and documents and yield identical pair-wise comparisons between vectors, they will *not* produce identical sets of coordinate points. We thus follow the approach proposed by Hamilton et al. (2016), which uses a Procrustes solution to find the optimal rotation for adjacent period models. A full account of the alignment strategy is beyond the scope of the present discussion, but available Cointet 2017.

### ***Summary***

Distances between any two articles on the model capture how related they are, *in general*, in the social world of a given period. But this structure is not itself interpretable. Consider how hard it would be for readers to agree on the two headlines in yesterday’s paper most related

“in general.” Nor would any answer that might be arrived at be of much interest to future historians.

Our goal is to capture a *specific* contemporary standpoint on documents’ meaning. We are not interested in what contexts particular ledes relate to “most” — but in a collection of ledes related in contemporary terms to our interest, that reflects its relevant context. A 100-dimensional space allows us to treat ledes and the events they represent as multivocal — having a multiplicity of possible meanings and organizational resonances for contemporaries, depending on the context. We now need only specify the perspective from which we want to consider the relationship between events.

An example will help to illustrate the logic of the approach. Imagine a location in the model space representing some social context or part of the world—itsself a standpoint—in light of which “relatedness” may be considered. For illustrative simplicity, let us imagine vectors as representing cities rather than events: Kyoto might be related to Tokyo more than to New York, London or Paris, considered from the vantage of international tourism. From the standpoint of climate change politics, however, Kyoto and Paris should be related, and unrelated to the others. Within the framework of national politics, we’d expect Paris, Tokyo and London to be related to one another, and not the other cities. (Of course there are some contexts to which we might wish to consider *none* of these entities related— extreme sports,

say— while from others—“cities” for instance — we might want to judge all of them as related.)

We propose that researchers can use the embedding space as a tool in precisely this way: to identify a location from which to describe collections of ledes related, for contemporaries, in the particular sense that interests them.

Crucially, however, standpoints become available as the world changes (Danto, 1964). Paris and Kyoto would not have been related in climate change terms before about 2015. But until the 1980s, they *could* not have been: a question about the relationship of cities, events, or anything else simply could not have been posed publicly in those particular terms. Our approach takes this into account: in order to constrain the researcher’s choice of standpoint to those available to contemporaries, we rely on the clustering of paragraph vectors on a particular period model. In the next section we propose to that researchers, relying on their knowledge of history and language, can rely on this property of the model to guide them to a set of articles representing a meaningful contemporary context. Specifically, we develop a protocol to allow them to identify a location on particular period model.

## **SEEDING**

### *Describing the domain of interest*

Our method for describing a collection of related ledes on a given period model is straightforward. We define a region of coverage by locating a point in the embedding space (a “Center”) and all the paragraph vectors at a given geometric distance (a “Radius”) from that point. The Center is located by averaging a set relevant paragraph vectors; the Radius is set at the discretion of the researcher.

The way document collections are defined as a “region” of the model space is thus simple. But finding the right one is complex. This necessarily involves navigating the asymmetry of perspective that Weber describes. The dilemma, in its present version, is *not* how to find documents that “are related” according to the model—that *is* the model. It is rather how to use the model to locate a collection of related documents that represent the *right* part of the social world. The standpoint on the world represented needs to be “right” in two different senses: for contemporaries, and for the researcher. That is, the document collection needs to represent a coherent “part” the contemporary social world. And the researcher needs to be able to orient herself, having parachuted into it.

In order to recognize contemporary parts of the world expressed as collections of ledes, we recommend that researchers *produce* them. That is: we propose that researcher identify a relevant region in the model space, through a series of informed choices. The steps outlined below are designed to channel these choices. They are *not* independent, rather they should

inform one another. We ask the researcher to guide the approach by 1) selecting a focal period 2) selecting a discourse. In both cases the choices are constrained by the requirements of our model, as described below.

First, we ask the researcher to select a delimited historical moment during which she is relatively familiar with the context she is interested in: some domain or “part” of the social

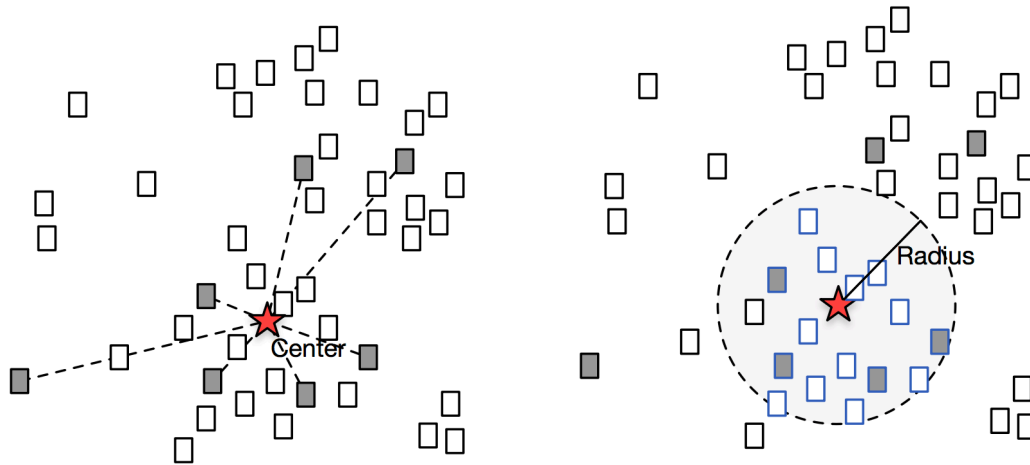


Figure III-2. Schematic representation of the technique for defining seed collections of documents, on the basis of the word embedding model of a particular period. The second shows the “Center” in the abstract space of the model, in relation to which a region of “related” vectors representing document (*Times* ledes) is defined. The first panel illustrates the way that a *discourse*—a set of articles, defined by the researcher— is used to identify that point in the model space, by averaging its corresponding set of paragraph vectors.

world publicly available to be represented in newspaper coverage. It should also be a period during which this the relevant context is discursively available contemporaries — where there is language that would pick it out of the social context. The set of possible focal periods is



delimited by our set of Period models.

Second, we ask the researcher to select a discourse that will identify the part of the social world of their interest, represented in the *Times*. Here we assume the researcher is able to identify at least some of the language that they used to talk about the things in connection with their concern. The most straightforward way to do define such a discourse is to simply select a word or term. For the sake of simplicity we hereafter implicitly assume that the researcher searches for documents containing a term: We refer to the term as a “Query,” and to the the set of ledes containing it the “Query articles” or “Query set.”

Formally, we assume that on the focal period model, the clustering of Query paragraphs coincides with some unobserved region of relative density of paragraphs overall. The vectors of Query paragraphs are first averaged to locate a point in the embedding space. This point serves as the Center defined above, around which a region of *relevant* coverage is described. *All* paragraphs vectors at a given distance from this point, including presumably some that contain the original Query and others that do not, define the seed collection. The researcher defines this threshold or “Radius” as a distance from the Center, above which paragraph vectors will be considered relevant.

To ensure that Query paragraphs meet the assumptions on which this method depends, the researcher should select discourse that meets two criteria. The first has already been

mentioned: the language should be relevant in the social world of contemporaries -- such that the clustering of Query paragraphs indeed overlaps with an area of relative density in the embedding space. While it may seem challenging requirement to meet, fact that domains are not constrained by any kind of scale — either formally in the model space, or at the level of the interpretable context of events described by the document set— in fact relaxes it significantly. In defining the Radius at which coverage will be considered relevant, the researcher has a chance to assess whether the domain her Query has identified is in fact too broad or too narrow to support her research inquiry.

The second requirement is in fact more stringent: The Query should identify ledes relating to a *single* domain. That is, if during a given historical period the term “house” appears in ledes relating to the part of the world that concerns disaster relief and flood insurance on the one hand, and in coverage of the US legislative body on the other, it would *not* be a suitable discourse to locate a coherent, integral context. In the next Chapter section we present a way of assessing how well ledes identified by a given Query meet this second assumption.

Again, practically speaking, the choice of historical period and the choice of discourse are inter-dependent— both should be undertaken with the formal assumptions of the model in view. That is, researchers wishing to use the technique should select a focal period during which they feel confident that the object of their interest would have occupied a single

contemporary domain, defined at an appropriate scale, and for which they can with some confidence find relevant contemporary words.

This approach to defining the seed collection of documents shares what we find plausible in keyword-based approaches to compiling corpora for analysis: We assume that researchers can generate language that characterizes *some* documents of interest for their analyses, *some* of the time. However we will show presently that for the range of historical inquiries that interest us here, even the static version of our document-embedding approach (described in this section), does quite a bit better than simple word search.

Finally it is worth briefly stating the reasons that we prefer this researcher-driven approach to a strictly mathematical one. The latter alternative might, for example, identify some optimal partition of articles in the embedding space, giving us “the” salient contexts, or topics of news coverage at a given historical time. For one, we find the assumptions necessary to most straightforward versions of this latter approach unreasonable: there’s no reason that given lede should, or would, be interpretable to newspaper readers as relevant to a single unique part of the world. To the contrary, it is doubtful that a single lede would be determinatively interpretable at all, absent a context of related articles, events.

The historiographic rationale for researchers to play a part in defining the collection of documents in light of which particular ledes are to be judged related or not, has been laid out

in detail above. Suffice it to say that such an approach, though constrained by the model of a given period, is *versatile*. Within that constraint -- that is limited by what can be seen as related by contemporaries, document collections can vary enormously in how they construct context; they are suitable seeds for a wide range of possible research inquiries.

It is also *transparent*. It is crucial that there exist some basis for assessing the success of the document selection strategy -- true both for the development of the technique, but equally so that researchers compiling these collections are able to assess whether they may confidently base further research on them. We will return to these issues, in particular the problem of how to evaluate the quality of document collections from a standpoint one has helped to define without “cheating,” in the following Chapter.

## **PROPAGATING**

Having described a region on the embedding space that defines a relevant social domain at a given moment, we can train our gaze across history. We propagate this “seed” set of documents to identify comparable regions across the dynamic model, and compile the documents falling within them. The resulting collection of articles reflects a continuous standpoint on the social world. That is, it is continuous not based on retrospective assessments

of documents relevance, but based on the observed language of the New York Times coverage, captured in the embeddings.

A detailed explanation of the technical aspects of each propagation approach is beyond the scope of this Chapter. However what Table III-1 captures is that during the propagation step we can vary our approach, such as to compile longitudinal collections of documents that reflect the social context defined by the researcher continuously in several distinct ways: we may capture events in the part of the social world in which the researcher's discourse is relevant, events that reflect the changing contents of a given domain as defined at some particular point, or events that reflect the way a domain evolves.

	<b>A [Continuous Center]</b>	<b>B [Adaptive Center]</b>
<b>1</b> <b>[Discontinuous Center]</b>	<b>1A (“Discourse” Center)</b> <ul style="list-style-type: none"> <li>- Identify the Center based on paragraphs constituting the discourse during the seed period.</li> <li>- Collect all documents whose vectors fall within the defined Radius of that point.</li> <li>- Identify the Center based on paragraphs constituting the discourse in historically adjacent Period models.</li> <li>- Collect all documents within Radius as above.</li> <li>- Repeat for each Period model.</li> </ul>	<b>1B</b> <ul style="list-style-type: none"> <li>- Average vectors of documents defining the discourse to identify an initial point in the model space of each period.</li> <li>- Consider all paragraphs within the Radius of that point.</li> <li>- Adapt: identify a new point in the model by averaging vectors of paragraphs within the Radius of the initial point: this is the adaptive Center.</li> <li>- Repeat for each adjacent model period.</li> </ul>
<b>2</b> <b>[Continuous Center]</b>	<b>2-A (“Propagated” Center)</b> <ul style="list-style-type: none"> <li>- Identify the Center based on paragraphs constituting the discourse during the seed period.</li> <li>- Identify this same location in subsequent/previous period models, relying on the alignment of these models. This is the new Center.</li> <li>- Collect all articles whose vectors are closer to the Center than the Radius.</li> </ul>	<b>2-B (“Adaptive” Center)</b> <ul style="list-style-type: none"> <li>- Average vectors of documents defining the discourse, to identify an initial point in the model space of the seed period.</li> <li>- Average vectors of documents defining the discourse, to identify an initial point in the model space of the seed period.</li> <li>- Consider all paragraphs within the Radius of that point.</li> <li>- In each adjacent period, adapt: identify a new point in the model by averaging vectors of paragraphs within the Radius of the initial point: this is the new Center.</li> <li>- Collect the articles whose vectors are closer to the Center than the Radius.</li> <li>- Identify this same location in subsequent/previous period models, relying on the alignment of these models.</li> <li>- Adapt as above, to find a new Center.</li> </ul>

Table III-1. Alternative strategies for propagating the seed collection, to compile documents in the equivalent context on the word embedding model.

Above we introduced an assumption about the organization of the embedding space on a given period model. Our assumptions about the distribution of paragraphs’ vectors over the

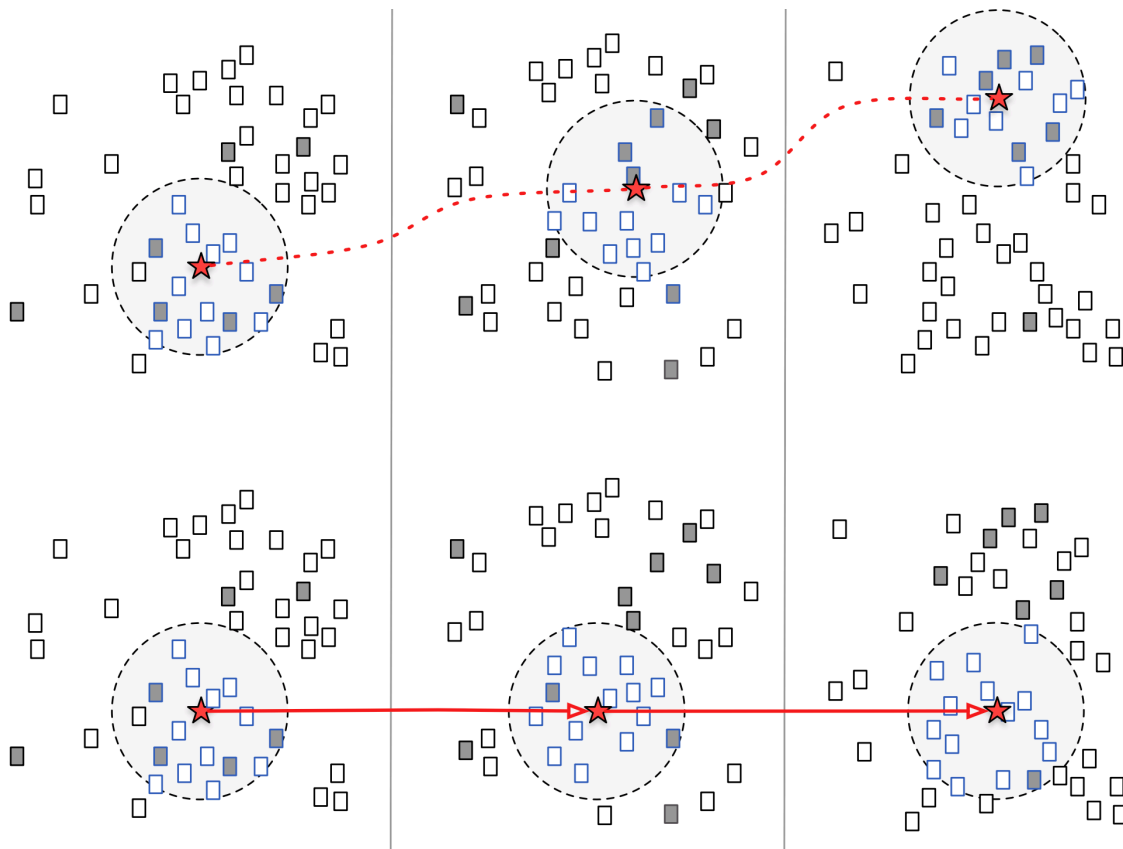


Figure III-3: Alternative approaches to propagating document collections. Schematic contrast of possibility 1A and 2A.

space licensed the approach we developed, which defined a context as the center of paragraphs representing a relevant discourse.

Consider the ways in which the organization of the world newspapers cover would would express itself in regions of the model space, from one period to the next. If the organization of the social world never changed, clusters of paragraphs representing events would reproduce themselves in the same geometric locations on the model over time. Historic changes in word

use, and even changes in, for example, the proper names of office holders — say the US president and his cabinet — should not affect the organization of the embedding space.

Of course, the world rendered in newspapers does change, however gradually: new concerns like human impact on the climate, or the “War on Terror” emerge, economic changes reorganize social life, certain parts of the world command more attention, as, for instance, the Japan did during its economic boom in the US of the late 1980s, or as the country’s opioid epidemic has done in recent years, while others fade from view. All of these changes have likely consequences for the organization of the model space overall. They also stand to affect the clustering of documents in the region of interest to us.

The alignment of Period models makes it possible to use the geometric coordinates of the Center and Radius defined in the focal period to identify the events constituting that same context elsewhere in history. That possibility is captured in the bottom lower quadrant of Table III-1. It is also schematized in Figure III-2, which contrasts two possible ways of re-defining a Center across periods, given the models alignment. Alternatively, however, it is possible to update the way that the context is itself defined, to reflect changes in the organization of the world rendered in newspaper coverage.

The second column in the table represents propagation strategies that take account of such change. In these cases, we consider how the domain—whether defined by contemporary



discourse (per row one), or by the discourse of the focal period (per row two)—has evolved, in relation to the rest of the world. To capture this we consider the language of ledes falling within the domain as defined in a previous period, and redefine the domain of the current period on the basis of these observed events. That is, we consider paragraphs vectors that would fall within the Radius of the previous period’s Center on the current model; we then update the Center by averaging these paragraph vectors. Articles at the defined Radius from this new Center define the new domain.

The approach of the adaptive strategies represented in column two allows us to capture what is specific to the a domain of a given period, endogenizing the structure of the embedding space as a whole. That is: this way of updating the domain reflects both change in the types of events that constitute it in from one period to the next, as well as change in the organization of the world *outside* of it. Recall the null hypothesis above: if the organization of the world represented in newspaper coverage changed not at all, we would expect domains to reproduce themselves period after period as clusters of events at the same density. The adaptation strategy accounts for a variety of sources of change. On the one hand, assuming our hypothesis about the organization of the space is valid, if a domain is “drifting” such that one aspect of the context receives more attention than other aspects, strategies in column two will reflect this drift: the center will be updated to reflect the new emphasis.

On the other hand, imagine that the world in general, or the larger part of the world in which the domain is located, is simply becomes more crowded with events, reflecting new sorts of concerns. We might expect a decrease in the relative density of articles that might otherwise have occupied domain-- and an overall *increase* in the density in the equivalent region of the model space. In this scenario, new types of events would occupy the edges of this region, and thus be permitted to affect the adaptation. Appropriately so, as we would want to say that the context of interest has changed, in this case not due to a differences in the type of the events, but because of change in the larger setting of which it is part, which we have allowed to affect the description of the context itself.

Our modeling approach aims to capture continuity in the world, based solely in continuity language use over time. Table III-1 thus seeks to communicate that there are different possibilities in the relevant *kind* of continuity seen in the social world. When, per the strategies defined the top row, we define the Center pertaining to the researcher-defined discourse, the adaptation should reflect the domain in which the discourse is pertinent. This can be seen by considering the fact that if the assumption that a researcher could identify an unobserved domain from a contemporary standpoint with her choice of discourse were *perfect*, there would be no adaptation at all during the focal period. (It would also suggest that our emphasis on the Weberian concern for how the one-sided standpoint of the researcher shapes her ability to identify an historical context had been overdrawn.) Of course, the assumption is *not* perfectly validated. For the results that we will consider in depth in the

Chapter Five, there are however relatively small differences in the collections of ledes is captured with and without the adaptation during the focal period, as compared to subsequent periods. This furnishes some grounds for confidence in the combined choice of focal period / discourse Query. More generally, we find that the collections identified using these two strategies represented in the first row of the Table afford useful standpoints on one another.

In the case of the continuous strategies, the adaptation has a substantive role to play. Put simply it allows us to track the evolution of the relevant domain as defined in the seed period, as it occurs over history. In Chapter Five we will have a chance to assess each of the four propagation strategies presented here. There we consider collections of *Times* coverage produced on the basis of these distinct approaches to document selection.

## CHAPTER FOUR: EVALUATING OUR OWN CONTEXTS

Our ideas about how the organization of the embedding space reflects the evolving organization of the social world, developed in the last Chapter, cannot be definitively confirmed. No one has ever *seen* the social structure of a particular period; it is a theoretical construct—itsself used to account for the patterning of what can be perceived. From what standpoint would we validate it? A search for the map of this territory leads only back, as the methodological debates among historical social scientists relying on newspapers show, to the newspapers themselves (Fransozi, 1987). Historical retrospect *does* provide such a map, revealing what *was* true of the organization of worlds of the past -- but our aim here is to censor that perspective, in order to recuperate contemporary contexts.

In this Chapter we provide protocols for approaching a more tractable question: Does the researcher obtain a “good” seed collection of articles? That is, does a given document collection gathered using the word embedding Period model on our approach represent a collection of event that identify a coherent contemporary context— and on the basis of which we can re-identify that context continuously over time? There were two *types* of features identified in the previous Chapter, that make a “seed” collection good: it should be good from two standpoints. Namely 1) it should reflect a context that would appear coherent *to contemporaries*—and 2) it should be a context which *the researcher can identify*. The first standpoint — the contemporary standpoint on documents-as-events — is given by the formal

assumptions of the model. The second is given by the researcher herself— her knowledge of history, and of her own interests. Here we provide ways that researchers can assess whether their collections are good from both standpoints.

The previous Chapter, this one, and the next, are all steps toward the empirical project of understanding deinstitutionalization’s reversal. They also attempt to make a methodological argument by example: Computational social scientists should not—and in any case cannot—avoid bringing theories of relevant meaning to bear on the choices we make. If we wish to achieve sociologically rigorous descriptions, we should embrace the interpretivist insight that the ascription of meaning is patterned. This implies attention to the problem of document selection: If we want to see the world as it appears from another standpoint, we must know, effectively, whose. But it also means a more earnest attempt to rework the asocial paradigms within which text modeling techniques have been developed. These include exercises to test whether and how well an analysis method “works.” The attempts to evaluate our seed collection presented here aim also to demonstrate how evaluations that are meaningfully risky might look. Like the techniques developed by computer scientists, our protocol stages a genuine test of the method’s performance. But that test does not depend on the assumption—only ever unmet—that the human evaluator lacks a standpoint for her choices.

## NATURAL LANGUAGE PROCESSING EVALUATION PARADIGMS

“Evaluation” of computational approaches to text in the field of Natural Language Processing is conceived of as an experiment: it stages a risky test of the performance of some language-related task. Evaluation exercises, as generally conceived in NLP, come in two types: “quantitative” and “qualitative.” The latter are distinguished not by the fact that they eschew measurement, but the fact that they involve people, characteristically described as “humans evaluators.” These evaluators are then presented with a particular task, for example, distinguishing a set of words that an automated method identifies, from some larger set of random words. The performance of the method is then are then measured against the human’s evaluations--what percentage of the human’s answers did the algorithm get “right.”

In the paradigm presented by computer scientists, human evaluators are not explicitly conceived of as having any particular standpoint. To assess this, we reviewed the different protocols proposed in the extended debate about how to evaluate the performance of topic models-- an automated method for categorizing text. When human evaluators were relied upon to assess how well topic models worked, these evaluators were constructed as having no demographic characteristics. Neither did we find any design that paid attention to situational factors, like whether the evaluation takes place in a university classroom, a business process

offshore center, or the evaluator’s smartphone. To the rule that humans are humans, when it comes to evaluation Natural Language Processing makes one exception: Experts. In some evaluation designs, evaluators who are theoretically specialists in some knowledge domain are relied upon.

The case of experts is exceptional in the following way. In NLP’s qualitative evaluation paradigms, questions regarding meaning, relatedness, topicality, coherence, and the other things evaluators are asked to assess are left unqualified -- at least, as exercises are reported in published results. Experts predicate the possible features of text identified in evaluation tasks, in a way that nothing else seems to do. Recalling the definition of standpoint offered in the last Chapter, as a framework for interpreting objects, we could say that qualitative evaluation techniques are insensitive to standpoint: They present humans with objects—words—with no way of thinking about what conditions the ability of the evaluator to tell the difference between them. This inattention to standpoint extended to the texts that are used for the evaluation exercises-- for example in corpora published at different periods in history occasion drastically different performance of the same methods (Newman, 2010). But this assumption of “no standpoint” is however unnecessary; and indeed the implicit structure of the best Natural Language Processing evaluation protocols.

In fact the best NLP evaluation designs, quantitative and qualitative alike, model standpoint implicitly in the *linguistic* contexts in which results are presented to evaluators. A good

example comes from the evaluation of doc2vec, the same vector space method we adapt in our document collection strategy. The evaluation seeks to assess how effective the method is at identifying paragraphs that are similar to one another. The authors train the method on a document collection that includes everything published on Wikipedia. Rather than attempt to generate “random” paragraphs, their evaluation is based on the following question: for a given paragraph positioned in the embedding space, is it possible to distinguish its nearest neighbor paragraphs, from paragraphs drawn at random from articles *in the same Wikipedia category* (Dai Olah and Le 2016).

Though not theorized explicitly, designs like the above enfold the notion of multiple contexts of meaning, the salient one of which may be triggered by the contexts of language with which evaluators are presented. There is no reason that an evaluation strategy needs to avoid modeling the standpoint from which it attempts to assess textual meaning. In Dai, Olah and Le’s design it is attention to standpoint that *makes* the test risky. That is what we try to achieve below.

## **EVALUATING THE CENTER**

The crucial step in our document collection approach is the identification of the Center—a point in the embedding space of a given period’s model. This is so not just because it



constrains the possible “seed collection” of ledes published during the focal period. This in turn has ramifications in the second step-- “propagation” -- in particular for the two adaptive Strategies (1B and 2B in the Table presented in the last Chapter).

The definition of the Center is so important, we suggested, that it should only be done by the researcher whose purposes drive the collection of historical documents in the first place. We also proposed a way for other researchers to do this. They should come up with a discourse—a keyword or words—that would identify relevant newspaper coverage, during a specific focal period of their choice. This and the Radius, the researcher’s threshold for what counts as “related”, thus define a region in the model space--and within it, a collection of documents, the seed collection.

The definition of the Center thus depends on the particular keyword that a researcher using our method chooses. It also depends on whether the assumptions they must make when selecting that keyword are met. We present protocols to test both things below.

***Evaluation protocol 1: Would the organization of the seed collection make sense for a contemporary?***

First we seek to test whether the researcher’s choices — of discourse and period — have illuminated the context that she intended. The result of the choice is a collection of ledes that ought to represent some publicly available part of the world to contemporaries — the one the

researcher had in mind. It is easiest to give an example from the perspective of future historians, relying on the technique described in the last Chapter to try to capture a domain we all are familiar with today: let us say the research interest is in today's culture of organized professional sports. The researcher knows something about this domain as it exists in the early 21st century: she thus focuses on our period, and selects discourse that she thinks will identify the relevant context.

What we proposed in the last Chapter is that the researcher can rely on this discourse, along with the regional organization of paragraphs in the embedding space, to guide her to a set of relevant documents. This collection of document-which-are-also-events will necessarily be “related” to contemporaries. (That is it will be so by definition—given our modeling assumptions, and assumptions about ability to choose a “good” discourse.) The question we want to get at here is whether the collection of documents identified by her choice of discourse is relevant *to the researcher*—ie does indeed capture the context it *is supposed to*.

Think of all the ways our future researcher might fail, with her choice of discourse, to identify what she was looking for: In a fashion-focused future, she might choose the word “jersey.” Presumably she would wind up with the metro-region coverage. It may be too much to ask the historian to recognize her mistake— in Thompson's terms, it may be too much to ask her to understand the past context in which she has mistakenly “landed.” In fact it *would* be too much: if the researcher can interpret any set of documents, things become suspicious.

What is not too much to ask of a researcher whose chosen discourse has identified the contemporary domain intended, is that she be able to recognize her own collection from a contemporary standpoint.

We can test this as follows: assuming that our future historian does in fact know something about organized sports at the end of the 21st century, she should be able to tell from the *organization* of the document-events in the region defined on the model through her choice of discourse, whether she has captured it or not. That is, a diligent future historian should be able to distinguish sets of ledes that correspond to basketball, for example, from sets relevant to football or baseball. This should be true if and only if her choices have captured what it was intended to—if her choice of discourse has landed her in the region of the embedding space related to “sports”, and not in New Jersey.

Below we propose a protocol for researchers to test their own ability to interpret the document collections yielded by their choices. (Note that we are here concerned *only* with the ledes in the seed collection. Within that collection we define the set of ledes for a given period that contain the discourse selected by the researcher as the set of “Query articles”, and the set of articles that do not contain the discourse as “non-Query articles.”)

## PROTOCOL 1

1. For the set of Query articles, cluster document vectors on the model of the focal period. The clustering can be done in any of a number of ways. Not all Query articles need be considered in defining the clusters. The goal is to identify at least two subsets of Query articles which are a) mutually exclusive, and b) maximally distant from one another in the focal period's embedding space.
2. The researcher then reads each of the subsets of Query articles and interprets them. She may wish to assign names to keep track of these interpretations.
3. The researcher is then blindly presented with the non-Query articles nearest the center of each of the subsets of Query articles.

The researcher is confronted with sets of articles which she has not seen. The test consists in whether in she is able to re-identify the distinctions that she applied to make sense of sets of the sets of Query articles. We suggest that this challenge be interpreted quite literally: the researcher should attempt to associate the names given in step (2) above with the previously-unseen document sets in step (3) to which the correspond structurally in the model space.

The new sets of documents with which the researcher is confronted represent distinct subregions of the of the seed collection defined by *her own initial choice of discourse*. The researcher's ability to validate the interpretations she has made on these new, unseen document sets is thus a test of both the coherence of the document collection *both* from the standpoint of the focal period, *and* from the researcher's own. We distinguish these conceptually in recognition of the fact that there is no way to do so practically. Assuming the researcher is indeed an historical expert, there is no better basis than her own.

We conducted this test using the Query articles in the seed period 1945-50 — that generates the three document Collections we rely on in the next Chapter. This researcher is pleased to report that the test is both difficult to succeed at without special historical expertise, and possible to pass with such expertise.

***Evaluation protocol 2: Does the discourse selected by the researcher identify a stable location on the model?***

There is a second *kind* of question we must ask about the researcher's choices. Do they conform to the formal assumptions necessitated by the model? Here requirements concern the researcher's ability to identify a region of *relative* density in the embedding space of a particular period. The more important of these requirements, we stated in the last Chapter, was whether discourse the researcher defined indeed captures what would appear as a single *unitary context* during the focal historical period.

The "region" of course is a collection of ledes. Here again, we must rely on the researcher. Given the limitations of historical standpoint, any judgements of about whether the assumption is met, with respect to a collection of events representing an historical context, is best made by the historical expert--the researcher.

Here we develop a way of testing whether a seed collection is unitary in the relevant sense. This test is pragmatic and self-policing. In conducting it, the historical expert pledges to do her best to prove her own choices, in defining the discourse, wrong. The researcher who is an expert should *want* to do this — it is no different than assuring oneself that one made the right choice. It is just one moment in the long process the of refining one’s research choices that Jack Katz calls “analytic induction.” Practically: it can be used to refine the Query discourse that defines the

The problem of choosing a discourse that respects the unintelligible distribution of document vectors in the embedding space is the one illustrated with the example of the different contexts of “house” (to live in) and “House” (versus Senate) as they might appears in newspaper coverage. Thus in this test, the alternative hypothesis about one’s Query articles is that they actually identify what from the standpoint of contemporaries of the focal period, would appear to be *different* contexts.

However a real historical expert, committed to beating her own choices, should be able to look at the ledes containing the discourse, and to identify among them *differences* in the relevant contemporary context. Again the imaginary future historian will be helpful: if “house” really does capture articles related to both flood insurance and USHR, then she should be able to distinguish the among the two senses in a sample of ledes representing the Query discourse.

We propose to that the researcher code such a sample of Query articles. (Here again: we define the set of Query articles as all those ledes that contain the researcher's keyword or keywords during the focal period). The coding should reflect any sense in which articles in this set might vary, given the social context visible to contemporaries. The researcher may apply as many coding schemes as she wishes. Here we coded a sample of 36 ledes, representing every article containing the term "mental hospital" during the focal period 1945-50. That is, we identified different senses in which the articles might vary for contemporary newspaper readers in 1945-50, and assigned to each article to a category on that basis. We coded the ledes in our set to capture: a) whether they referred to the activity at the local, state or federal level, 2) whether they referred specifically to the psychiatric profession or not, 3) whether or not they were "human interest" stories -- that referred to individuals, and so on.

We can thus finally apply the standpoint of an expert, to test the assumption that the articles constituting the discourse — that is, containing the Query— indeed identify a unitary context.

We may do so by removing articles from the Query set one by one.

When we remove articles randomly, the location of the Center that this set defines should remain relatively unchanged—relatively, that is, compared to when we remove articles systematically. This is the role of the coding schemes. They represent the researcher's best

possible guesses as to the distinct senses of the Query articles from the contemporary standpoint — “house” and “house.” If our codes identify meaningful variation within the Query set in relation to the model space of a given period, with respect to defining the Center, removing all the members of the Query set assigned a particular code should make a noticeable difference, in terms of the articles captured around it.

Figure IV-1 displays the results of a simulation that allows us to assess just this. For the ledes we coded—the Query set defining the Center—it gives the shift achieved by the deletion of members of the set. The “shift” is given as the proportional overlap of the new set of document vectors in the region around the new Center (with members of the Query set deleted) as versus the old Center (without deletions). We simulated removal of a given number of documents from the Query set at random (and in random order) 1000 times. We compared this to the removal of documents in the set according to our coding categories.

The assessment is quantitative in the sense that it relies on measurement. But there is no way of “passing” this test quantitatively. What it measures, effectively, is the extent to which different hypothetical variations in the researcher’s initial Query are expressed in different collections of “relevant” events. The variations represent the researcher’s best attempt to make sense of the relevant contemporary context of the discourse, captured in the embedding space. Because we can recognize the source of such variation—our own categories, as applied to a set of documents—we can use it to refine the context we capture. That is we can



use it to refine “what we mean” with respect to the embedding space when we define the discourse in the first place: to the extent that we can recognize sources of variation in contemporary terms in the Query set, we can reconstitute the Query so that it captures what we are looking for.



Figure VI-1. Random versus systematic deletion of articles from the Query set.

Displacement of the Center is expressed as the proportion of overlap between the two document collections. The Period model is for 1945-50, and the Center is once again defined by articles containing the term “mental hospital.” The x-axis represents the number of articles removed, either at random (blue) or on the basis of the researcher-assigned categories (the points represent the remaining coding category, when other articles were removed). The y-axis represents the proportion of overlap in the resulting document collections. That is, it represents the proportion of unique document vectors in the set defined by their distance from the new Center, that are also captured at the same distance from the (old) Center— defined by the full set of Query articles for “mental hospital.” (The Radius defining the distance remains the same.) Here the blue lines represent the mean and standard deviation of overlap in the document sets, based on a simulation of random removal (in random order) of document vectors from the Query set. The dots represent the systematic removal of articles to which I assigned codes, and the labels represent articles whose code was not removed. Hence for example the green dot labeled “3\_I” in the bottom right hand region of the figure indicates that all of the articles except for those coded “international” were removed. Hence we see that articles in the Query set that got the other categories— namely “state”, “national” and “local” — make a greater-than-random contribution to defining the Center: it appears below the curve indicating the expected overlap. This is equally true for of another dot, labeled, “3\_L”: 3 part of the same coding schema that was assigned to distinguish the scale at which events reported in ledes in the query set were relevant. Thus we may infer that for contemporaries, the context in which mental hospitals are relevant during the period is fundamentally a state and national one. We might improve our Query by dropping the local and international coverage from our discourse.

## CHAPTER FIVE: DEINSTITUTIONALIZATION'S CONTEXTS

Understanding psychiatric deinstitutionalization as a reversal affords a standpoint from which to reconsider the variety of activities that might constitute a movement on behalf of the mentally ill. Specifically, it allows us to analyze why, once the goal of deinstitutionalization was inscribed in policy--and undergoing reversal--such a movement did not act again to redefine both its goals and its sources of support. But this in turn demands that we define the period over which the question is relevant.

The following chapter confronts the problem of “casing” or periodizing the social movement on behalf of the mentally ill. I approach this problem with a specific premise: that the continued existence of a *target* around which the activity of a set of variously-positioned, more-and-less-organized groups might have been (re) oriented, conditioned the movement’s existence.

Such a target perforce must be public— that is, it must be visible to contemporary actors. Delimiting such an object in time means obtaining a consistent view of the relevant context for movement activity for them, as transformation proceeded. This, of course, is the role of the document selection technique developed in Chapter Three. The present Chapter applies the technique developed there to reveal several different respects in which the social context of the mental hospital at midcentury evolved, as collections of reported events.

Analyzing the resulting collections of *New York Times* ledes serves two purposes. First, it tests the utility of a method. The approach to document collection developed in Chapter Three is used to produce the document collections presented in this Chapter. I examine the resulting collections in a variety of ways, including reducing them to their semantic networks. I hope that my familiarity with the context of deinstitutionalization, as seen by a variety of actors, helps to make the case that my interpretations of these materials are not inevitable. But they are coherent with what could have been perceived. On the other hand, these interpretations are only possible because of what we know must be true— about the standpoint from which we arrive at them.

Substantively, the text analyses reported in this Chapter allow me to identify the disappearance of a target around which a movement on behalf of the mentally ill might have viably redefined itself. Informed by an understanding of the key structural shifts involved in deinstitutionalization (developed in Chapters One and Two), the document collections afford a number of insights into the evolution of three different continuous contexts, captured in events that the *New York Times*. Among them is the fact that, by the early 1970s, mental health has vanished as a visible concern of the medical field.

The disappearance is of course ironic. The condition for mental illness to appear as “no longer” a medical concern was an expansion of the healthcare marketplace. Thus the

disappearance of mental health from the public context of medicine, among other observations from the Collections, allows us to pose new questions about coordinated action on behalf of the mentally ill. What were those possibilities like, the moment before reorienting the movement to a target in the medical field closed?

The present chapter proceeds as follows. I expand on the challenge of “casing” the movement on behalf of the mentally ill, and develop the argument that the existence of a relevant target provides a basis for doing so. I explain the selection of the seed period and discourse—per the method outlined in Chapter Three. I then apply our propagation strategies to compile four corpora. Interpretations of three of them are offered. I conclude with a discussion of how this enables us to identify the disappearance of a relevant target, and thus to “case” or periodize a movement on behalf of the mentally ill.

## **WHY “CASE” A SOCIAL MOVEMENT?**

From the end of the World War II through the 1980s a variety of individuals and groups advocated actively for changes to the mental hospital system—changes consonant with what would appear as deinstitutionalization. An even broader constituency lent their support to these efforts--supporting legal reforms to commitment procedures; donating to advocacy

organization, and cheering the civil rights victories of the mentally ill. Even (possibly especially), among the most active of these more-and-less organized elements, those involved did not always find one another sympathetic: ex-patients groups hated even “radical” psychiatrists, eg. Nor did they speak the same language. Some scholarship that regards movements as the crucible of new identities, insofar they organize unique cultural sanctuaries for their participants (eg Armstrong 2002). But when we look at those who advocated for change to the mental hospital, the basis on which groups organized (“radical *psychiatrists*”) suggests a hardening of the identity of those on whose behalf action was undertaken. The reversal undergone by deinstitutionalization puts pressure on the question of how to decide what activity should be counted as part of the “the movement”—or more specifically, until when it should be.

In one classical framework, social movements are defined as challengers to the social order. They target incumbents -- established elements of the order -- with demands on behalf of some beneficiary group (Schwartz 1988; Gamson 1975). Within this framework, sociologists have typically approached movement activity as ideally *rational* collective action, that is, oriented to the achievement of some particular goal (Gamson 1977; McAdam 2010; Benford and Snow 2000). For Gamson and others in this tradition, the definition of the movement actor is thus unproblematic: it includes any individual or group joining in the challenge. The temporal horizon defining the movement is likewise straightforward: it concludes with the

abandonment of the challenge, either through success—in the form of “acceptance” and or “new advantages” for the beneficiaries—or failure.

A key element of such a view, and the crucial innovation of this body of scholarship, is that it need not entail any particular assumptions about the constituency of the movement. It need not, for instance, assume that activity is rational on the individual level; nor need it define membership in the movement based on the identities or ascribed social positions of the participants. Thus the view of movements as rational actors licenses a program of research into what conditions the outcome of their challenges; i.e. the accomplishment of movement goals.

Within this framework, the demands of sundry mental health reformers would clearly have constituted a challenge. The historical reversal of deinstitutionalization, however, makes plain what is unsatisfying about approaching movement activity as Gamson and others have done, through goals. The grounds shift under the feet of challengers and incumbents alike: Challenges directed at today’s incumbents become boons for the incumbents of tomorrow.

Consider the observations of one sociologist of mental illness, offered in 1981: “Providers and administrators have set up advocacy offices, posted patients’ bills of rights, and incorporated ex-patient representatives on advisory boards. [...] The conjuncture of the movement with

economic impetus toward deinstitutionalization has allowed mental health planners to use [the patients' rights movement] to justify their essentially fiscal policy," (Brown, 1981: 523).

With regard to collective action on behalf of the mentally ill, more relevant than explaining success or failure would seem to be the following: As deinstitutionalization progressed, and the economic basis of support for the mentally ill shifted, what prevented the movement from redefining itself-- that is, what prevented it from acting to redefine its goals, and its sources of support?

But addressing this more fruitful question requires us to define the historical window of its relevance. This is so because activism by and in the name of the mentally ill did not end with deinstitutionalization. When it comes to movement "activity" one sees only a continuous flow: the founding of membership-based advocacy organizations by former conscientious objectors in the 1940s, a fivefold increase in donations to lay mental health advocacy organizations over the fifties 1950s (Kadushian, 1969), the emergence of ex-patients groups in the 1960s, and starting in the early 1970s, their collaborations with civil libertarians (Brown, 1981; Rothman and Rothman, 1984), the founding of National Alliance for the Mentally Ill in 1977, the publication of Madness Network News 1972-1986, the emergency of consumer/survivor advocacy groups in the 1980s... Scholarship can be found periodizing mental health "activism" around each these moments (see for instance Sayeran, 1994; Anspach, 1979; McLean, 2000; Chamberlin, 1990; Dain, 1989).



In some ways, the organizations that emerged in the 1980s looked more like the successful movement organizations of classical sociological treatments like those of McAdam, Zald, Snow, Gamson and others. But in addition to facing a transformed political environment (as described in Chapter One), the goals they advanced failed to unify the mentally ill. NAMI, founded amid the various discoveries of deinstitutionalization and revelations of its failure as policy on the national level. It leveled claims for more public resources on behalf of the mentally ill, but also advocated for the reinstatement of involuntary commitment law (Chamberlain, 1990; McLean, 2000). The mental health advocacy of the 1980s and 1990s, equally, found “consumers” and consumer advocacy groups on all sides of a given policy conflict (Tomes, 2006). One could say of these activities: There was no single object at which claims or demands were directed. Collectively, they lacked a target.

The mental hospital system itself had of course itself once afforded such a target. The institution had, in an important sense, created the “mentally ill” as a legible social group--distinct from unwed mothers, cripples, and the variety of other persons considered incapable of leading socially productive lives, the population that belonged in almshouses. While the fate of this category of people so closely identified with it, the mental hospital could effectively channel action on their on their behalf, and as deinstitutionalization, on their part. The hegemony of mental hospitals -- that could organize supporters with different motives.

Mental health activism of the 1980s however lacked such an object around which it could direct claims on behalf of the mentally ill—it failed to discover one.

A target is not itself a “challenge”—and it is certainly not itself a movement. What I suggest here is that the persistence of a target is an analytically reasonable basis for defining the persistence of a movement, as a challenger to the social order as it exists at a given time.

Action on behalf of the mentally ill might presumably have posed a *different* challenge to the social system for dealing with mental illness. The remainder of this chapter is oriented to the question of precisely how long such a possibility presented itself.

## **TEXT ANALYSIS**

### ***Choosing a Focal Period and a Discourse***

The logic by which I chose the 1945-50 as the “focal period” for all three document collections will illustrate the constraints described in the abstract in the account of the method in Chapter Three.

The years following World War II constitute a common starting point for histories of contemporary US mental health policy (Mechanic and Rochefort, 1990; Grob, 1991; Torrey 2014). Narrative accounts of deinstitutionalization apparently cannot avoid devoting

considerable focus to developments set in motion during those years— among them, the ascendancy of a new generation of psychiatrists socialized by the experience of WWII (Grob 1991: chs 5-6), the founding of the National Institutes of Mental Health (Starr, 1982; Torrey, 2014), and the role of conscientious objectors who were put to work as attendants in understaffed state hospitals during the war (Sayeran, 1994; Taylor, 2009; Grob, 1991: ch 4).

Later on, these steps would appear to have paved the way for large-scale transformation of the state-run system of custodial mental hospitals.

As a result of the scholarly focus on this period, we know quite a lot about the way that the United States dealt with mental illness in the years 1945-1950. Though historians have located origins of change here, the distinctive features of the custodial system that would later give way were still in place: Most inpatient episodes took place in publicly run hospitals; and the majority of the commitments were involuntary. It thus a good candidate period on which to focus.

Additionally, during this period the two assumptions crucial for our document selection strategy hold true. First, the mental health treatment system was *discursively available* to contemporaries. After experiencing years of neglect during the Great Depression and then the war effort, the country's mental hospitals suddenly attracted increased attention from the media, politicians, and the public during demobilization (Grob, 1991: 70-76; Rose, 1979; Warren, 1981).

Second, we can confidently assume that the public view of mental illness and its treatment, during the late 1940's, would have located the matter in a *single* social context. "The psychiatric view of a person becomes significant only insofar as this view itself alters his social fate—an alteration that seems to be fundamental in our society when, and only when, the person is put through the process of hospitalization," Erving Goffman could write, as late as 1959 (1968[1959]: 128)—it was simply a succinct formulation of the obvious point of view. During the five years following World War II, contemporary views regarded mental illness as defined by its treatment, and treatment as defined in turn by time spent in a mental institution. We can thus assume that references to these things would define a single context in newspaper coverage. (In the Evaluation section, we proposed a way of testing the second assumption.)

Asylums, state hospitals, mental institutions, psychiatric centers— a variety of terms were used over the institution's long history in the US. A look at the canonical postwar media exposés by Albert Deutsch and Mike Gorman suggests that during the focal period suggests "mental hospital" as the most relevant discourse of the moment. The more than twofold increase in the number of *Times* ledes containing the term in 1945-50, as compared to the previous five year period, gives us confidence in the choice of that discourse to locate the relevant context of documents.

We thus collected all *New York Times* ledes containing the discourse “mental hospital” and averaged their paragraph vectors to identify a Center in the embedding space of period 1945-50. Distance from this point in the embedding space defines the sense in which we will consider ledes related. It constitutes our standpoint on events.

We then applied each of the propagation strategies, as described above, compiling four different collections of articles. We refer to them below by the names of the strategies that produced them as defined in the Table of Chapter Three. Here we focus on three: 1A, 1B, 2A, 2B.

Figure V.1 shows the simple counts of articles that comprise each collection over time. The dotted line in the figure indicates the number of articles containing the term “mental hospital” in each five year period, making it obvious that in almost every period, each of our four document selection strategies captures many more documents than would a keyword-search based approach to compiling documents. Before going on to interpret these collections of articles it is worth appreciating the difference between what would be what a keyword search would capture, and what is captured using the document embedding strategy we have developed, on the level of events defining the Collections on the two approaches.

The difference can be illustrated simply, by considering the articles at the center of the context defined by “mental hospital” on our approach, as versus those that would be found in the

same period if one simply selected ledes containing the term (per the illustration, in fact, in Figure III-1).

Below are the three articles closest to the Center of the paragraphs containing the term “mental hospital” on our approach, during the 1950s:

*State Gets Funds for Nurses. PHS gives \$102,455 to NYS Mental Hygiene Dept and State U Med Center to train pub health nurses in mental health research methods.*

*FAMILIES CHIDED ON CARE OF AGING; Expert Says Many Elderly in Mental Institutions Should Be at Home Amer Psychiatric Assn repts study shows 30% of all patients in mental hosps are over 65 yrs old, rept to Mental Hosp Inst; Dr Bartemeier holds many do not belong in insts; notes problems of home care; Repr Fogarty urges foster-home care.*

*MENTAL HEALTH GRANT; State and U. S. Allot \$69,128 to Jersey Psychiatric Clinic Union County Psychiatric Clinic gets Fed, state grants.*

Notice that *none* of these texts contains the *term* “mental hospital.” Yet all of them clearly relates to what, in the 1950s, would have appeared part of the relevant institutional context.

By contrast, below are three articles from the same period that *do* contain the term “mental hospital,” but which were not close enough to the Center -- either of the articles containing the term, or indeed, as defined on any of the other three strategies -- to be captured in any of our four samples.

*DR. JAY HOFFMAN, PSYCHIATRIST, 47; Physician at a Washington Mental Hospital Dies--On Medical School Staff. Hoffman, Jay L.*

*PEIPING ACCUSES U. S. ON STUDENT; Washington Examining Case of Mental Hospital Patient It Has Tried to Deport State Dept probes Communist China complaint to Amb Johnson that Chinese student Liu Yung-ming, mental patient in Missouri State Hosp since '49, is held in US against will; hosp chief comments*

*Forcible Removable Reported. BATON ROUGE, La., June 2 -- The removal of Governor Long to a Galveston hospital in a National Guard airplane on Saturday is reliably reported to have been carried out against his will. The Governor of Louisiana is immune to commitment to a mental hospital while in his home state.*

The first of the ledes speaks for itself. It is an obituary, and only incidentally concerns mental hospitals as the site of the deceased's career. The second refers to the case of a Chinese university student diagnosed with schizophrenia. The full article has little to do with the details of Liu's hospitalization, and much to do with US relations with China's relatively young Communist government. The last concerns a remarkable episode in Louisiana state politics, in which the wife of sitting Governor Earl Long, likely working in coordination with his political rivals, attempted to have her husband removed from office by committing him to a Texas mental institution. Exceptional as an event, it makes great news—but would not have been part of the typical context in which mental hospitals would have been relevant in the 1950s.

### ***Interpretative tools and methods***

To interpret the document collections compiled on each strategy, I did three things: First, I considered the quantitative features of each collection, and of each collection in relation to the others. I explain these measures in greater detail in Appendix I, and provide some relevant visualizations.

Second, I read extensively, in a disciplined fashion. I drew a sample of more than 500 ledes, representing ten randomly drawn articles over the fourteen five year periods (the same periods for which we trained word embedding models), for each of the four collection. In reading the sampled documents, I tried to answer the following question from the contemporary standpoint: what part of the social world does this particular set of events relate to? Where the documents demanded it, I made extra effort to understand them from the relevant historical point of view, for instance when ledes made reference to events, people or other entities with which I was unfamiliar, I looked up them up.

Finally I carried out semantic network analyses and visualization of three of the four collections, based on the interpretations of the above. I extracted from each collection its most frequent noun terms. Based on these terms, semantic networks that reflect the co-occurrence structure in the documents collections were built. Clusters, represented in the Figures below by were identified using the Louvain algorithm. In the case of Collection 2A, the network is constructed across historical time. Flows in the semantic river network capture connections between co-occurrence network clusters in adjacent historical periods. The semantic network construction and visualization techniques in general, and the river network technique in particular are identical to those presented in Rule, Cointet and Bearman 2015, and also developed in Chalavarias and Cointet 2013.



I comment below on collections corresponding to three of the four document collections produced. Collection 1B is not presented separately, but helped to inform the interpretation of the other Collections. Material used to interpret all four of them is presented in the Index. Below I refer to each document collection by reference to the strategy used to generate it, e.g. “1A,” “2B,” etcetera.

### **THREE CONTINUOUS CONTEXTS**

#### ***1A: The domain in which “mental hospital” is relevant.***

Deinstitutionalization was a process named after the fact. “In New York State, for instance, it took over twenty years for the negative aspects of discharging large numbers of patients to the community to emerge,” observes one study of the state’s mental health system (Johnson, 1986: 503). The first corpus we compile provides a way into what this process looked like as it was happening: it captures events that in the part of the world in which “mental hospital” would have appeared most relevant. Semantic networks reductions of this corpus, presented below, reveal a context coherent with what we know could have been perceived.

Semantic network reductions of this document collection were made over five periods of equal historic span between 1945 and 2015. Each represents co-occurrence patterns of the 150 most frequent noun terms over that period in this particular collection of reported events. The

evolution of the network observed can be stated briefly—it is both clear in the visualizations, and a plausible rendering of the public context of the mental hospital during the process of deinstitutionalization: From the nineteen fifties onward the mental hospital became gradually less integrated with a broader medical field; it becomes related to the courts, and, it is eventually absorbed by the carceral state; still later it is eclipsed.



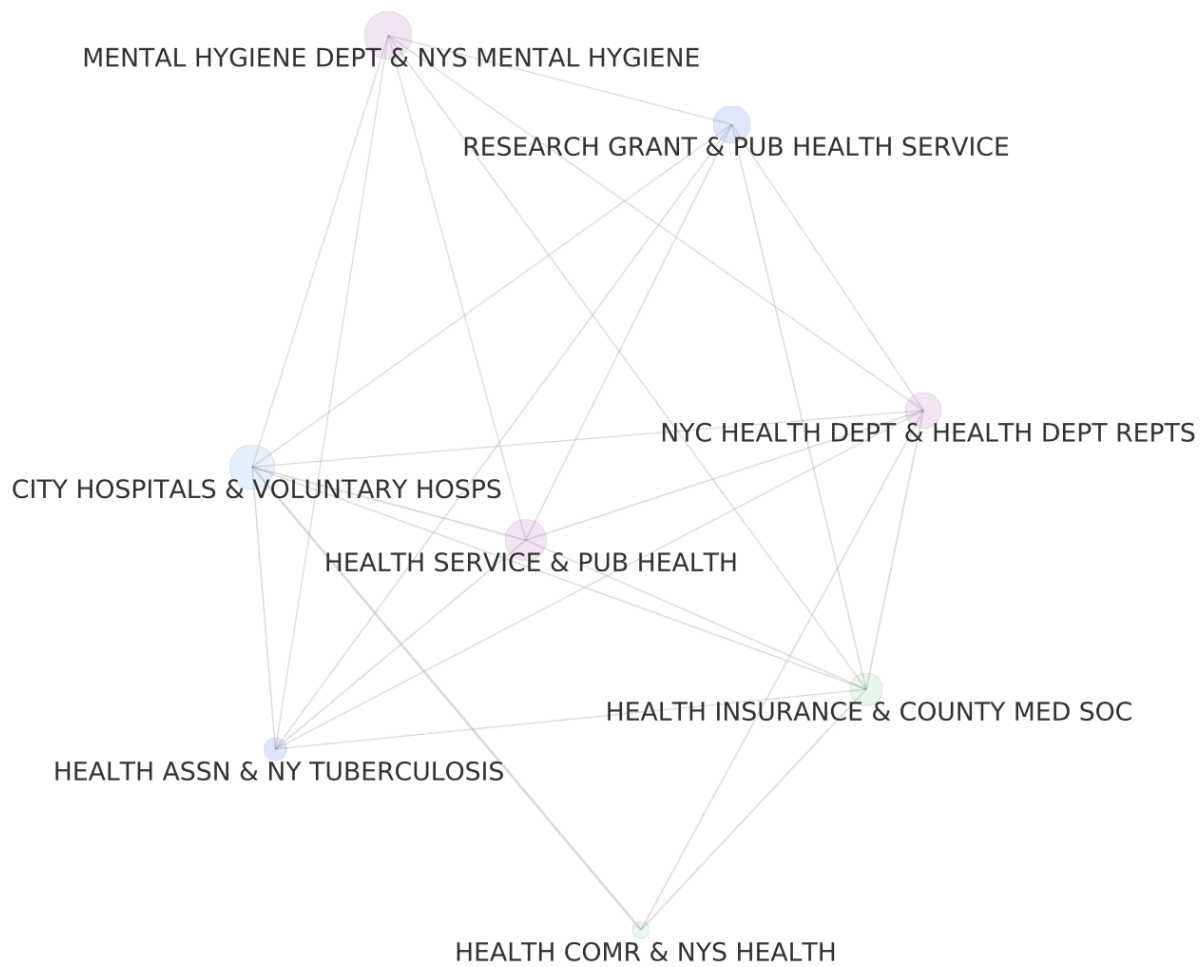


Figure V-2. Collection 1 A: The context of “mental hospital” seen from the *New York Times*, January 1945 - October 1958. Reduced semantic network based on 150 x 150 terms matrix representing the collection of ledes gathered on propagation on strategy 1A (see Chapter III). Labels are automatically generated, and represent central nodes in each cluster.

The transformation is clear thanks in part to what is obvious, and yet also surprising, the “mental hospital” discourse of the early period. The network visualization in Figure V-2 reveals, in abstracted form, the context of the mental hospital as it might have appeared from the end of the second World War until about the end of the 1950s. Clusters in the term co-occurrence network interpreted as sub-domains-- distinctive elements of the social context of which “mental hospitals” appeared part.

The Figure V-3 is provides further abstraction of the *same* semantic network: The labels are automatically generated, they reflect the terms that best distinguish the cluster, structurally. During the period of 1945-1958, it is hard to improve on the clarity of the automatically assigned labels in the reduced network, when interpreting the same network with . The region of the network encircled in purple, in the the top left hand corner captures the activities of New York State’s Department of Mental Hygiene. Clockwise from it, in blue, are the health-related activities of the federal government, at the time under the Public Health Service. These included sponsoring research, as well as certain forms of what would today be called health care delivery--for example, “rehabilitation” of veterans and other cripples. The matching dark blue region at the far left hand side of the visualization reveals that this distinct subregion is, according to the Louvain algorithm, of the same cluster. Equally the two other regions described by purple circles — one encompassing (on the right) activity led by the State and City’s Health Departments, and the other (at the very center) what we might call “family

health”, encompassing pediatrics and nursing homes — were both also part of the domain of the state. The term “Mental Ills” clearly ties the latter together.

The regions in light blue capture the New York City hospitals, drawing together both the municipal and voluntary hospital systems. This clique of terms forms part of the same cluster with a smaller one, of the same color, at the bottom of the network. Finally, at the bottom right hand corner of the network representation, the green cluster captures what we would today refer to as the private sector: here are county medical societies (local-level units of the American Medical Association), and health insurance. The cluster includes some terms that may reflect the debate around and ultimate failure of a national health insurance plan (“soc welfare” and “national health”). Notably “mental hygiene clinic” is here too. The term appears to co-occur most with “health service” and “county med soc”. This is in fact hardly surprising given retrospective accounts that focus on the dis-articulation of such clinics from the state hospital systems (eg Lerman, 1982). But it does give a sense of how much relevance to the mental hospital system these clinics appeared to contemporaries to have -- and indeed, how much they had to do with “Mental Ills.”

It seems intuitive that the particular *medical* context for mental hospitals, apparent at the level of the network visualization, would also be evident to a contemporary reader of the ledes in 1A Collection. Conversely however, it might come as a surprise to us that of the documents in

Collection 1A, on which the network above is based, only a minority make *explicit* mention of mental illness or mental health, as I could recognize it.<sup>9</sup>

The random samples of articles drawn from Collection 1A included coverage related to blindness, to physical disability, and to juvenile delinquency. Today's newspaper readers might have a hard time seeing the common thread among these articles; it's certainly unlikely that they would be read as having much relevance to medicine. But in the mid-twentieth century US, these conditions had something in common: like chronic diseases ranging from tuberculosis to epilepsy, they frequently meant confinement in publicly-run custodial institutions. Often, as in New York, these institutions were under the administration of the state Department of Mental Hygiene.

From the standpoint of a contemporary reader in the forties or fifties, in other words, such a set of articles would have made perfect sense: such events captured a "part" of the world, as then institutionally defined. The mental hospital part-of-the-world *was* the tuberculosis part-of-the-world was the rehabilitation part-of-the-world. This was not necessarily the case from within such total institutions granted, but it was on view of the public informed by *The New York Times*.

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<sup>9</sup> The assessment is based on my reading of the random draw of 10 articles from each Collection over five year periods. In doing this reading, I kept track of all the articles I recognize as referring specifically to mental health. For each of the three five year periods through 1945-50; 1950-55 and 1955-60, this was the case: only the minority of articles referred specifically to the mentally ill.

The mental hospital was *also* part of the world of medicine and hospitals generally; including municipal and voluntary institutions. Mental hospitals were a big part of what hospitals *were*. This impression is based on the semantic network, is confirmed by the data At the close of World War II there were more beds in public and voluntary general hospitals *combined* as there were in hospitals for “Mental Disease” (Statistical Abstract of the US, also see Hollingshead and Redlich 1958).

The 1955 “mental hospital system” described by historians was real enough, but it is an object abstracted from this wider context. To point as much out is of course *not* to assert that mental illness had no independent social reality during the nineteen-forties and fifties, which would flout the facts. During these years, for example, the yearly census of Institutions for Mental Disease made by the Public Health Service distinguished between institutions for the “mentally retarded” and “epileptics”, the “chronically mentally ill.” Such distinctions were available at midcentury thanks to professional psychiatry, and in an important sense, thanks to the history of the asylum itself. It is their continued salience of mental illness *today* that provokes us to illuminate—to use Weber’s imagery—the significance such distinctions had in relation to the social structure of another period.

With this extended discussion, I hope to have provided some initial support for the tenability of the ideas guiding the word embedding approach to document selection presented in Chapter Three. The documents over the beginning of the period covered in Collection 1A, on



which Figures V-2 and V-3 are based, appear to capture precisely what the document selection method was designed to capture. The reduced network says it all: the collection of documents sensibly reflects contemporary institutional distinctions, during the focal period, during which we define the context for subsequent events. They are comprehensible to the historical researcher in light of her own concerns, but would not necessarily be obvious to her on the level of the event—that is, on the level of the specific *Times* lede.

The same is true of the rest of Collection 1A, over the remainder of the collection. On the same basis we can observe important developments in the way the context of mental hospitals revealed in 1A as it evolved. They are captured in reduced networks for the three corresponding to that in the upper right hand of Figure V-2, in Figure V-3.

Starting in the 1960s the relevance of mental hospitals begins to shift: the institution gradually loses its broader medical context. The reduced semantic network visualization of the next two periods, rendered in the top and middle panels of Figure V-4, reveals the increasing isolation of state mental hospital system, as it would have appeared to contemporaries. Comparing the semantic networks of 1945-1958 and 1958-1972, the difference in structure is striking: communities in later period's network are far more distinct, less connected to one another.

Though more isolated, the communities in this second period are recognizably related to those of the 1945-58 network. In Figure V-4, panel (A) we see a cluster in which “Mental Patients” is now the unmistakable hub. New York State Department of Mental Hygiene (top)



is clustered with the Health Department, as well as the cluster representing activity of the federal government, though fewer terms constitute it. The mental hospital system is tied, on one hand, to the NIMH, and on the other, to the city hospital system visible at the center of the network.

In 1972-86 the striking development in the semantic network is the appearance of a cluster representing the justice system. It appears right in the middle of the terms network, encircled in dark blue in Figure V-4 above. In its relationship to the structure as a whole, dominated it would appear to have replaced the NIMH in its relationship to DMHs. Relatively high coherence of around the Center on the embedding space, of of the 1A document Collection as well as 1B around the Query Center in model space the during these periods is suggestive of what is qualitatively apparent: Reading the relevant ledes too, we see that by this point and the institutions run by the NYS Department of Mental Hygiene are now clearly the targets of attack, mostly for their treatment of patients.

1980s another shift in the focus of ledes included in the random draw occurs: In the 1970s “mental hospitals” have clearly to do with the courts— which facilitated litigation on behalf of their remaining patients. By the later part of the decade, however, we observe (again both from the semantic network as and from reading random draws of the ledes) a new relevant setting, which is clearly the criminal justice system. The semantic network for the period 1986 to 2000 makes that by that time, the mental hospital has been absorbed by the. Theories of

the relationship between the asylum and the prison discussed earlier have a basis— in the continuous visible context in which “mental hospitals” appeared.

Starting in the early 2000s, mental hospital discourse loses a clear context all together. Though there are documents in the collection, there is no semantic network for the last period. None of the terms that occur most often in the document collection over that period, themselves appear together in ledes frequently enough to appear.

Deinstitutionalization likely first appeared to New Yorkers as a deepening crisis of the city’s municipal hospital system. Random draws of articles from collection 1A in the period of 1960-1965 appear different in focus from those of 1955-60. The sample draw reveals two changes, in relation to that over the previous five years: an increase in “human interest” stories, that focus on bizarre and violent events involving the mentally ill outside of institutions—though these were present, a deeper inspection of the corpus reveals, on previous period too.<sup>10</sup> It also shows a large increase in coverage of the city’s municipal hospital system.

The New York City public hospital system had, by most accounts, been beleaguered but popular well into the postwar era. In the late 1950s and early 1960s the conditions of the city

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<sup>10</sup> The fact that such stories are not absent from the 1A Collection in previous periods, together with the fact that the average article density around the Center in the model space suggests that this reflects a change in the *Times* coverage. That is, it appears not to simply the result of the slackening of coherence of the Query discourse, but to reflect instead a change in the proportion of such articles in among those that make up the set containing “mental hospital” In fact this was one of the



Local observers were apparently optimistic that the 1965 introduction of Medicaid and Medicare would save the municipal hospitals, providing a much-needed influx of cash. Historian Sandra Opdycke describes how, instead, these programs decimated the municipal hospital system. As a large segment of the middle class and “deserving poor” were able to seek medical care on the private market, they abandoned the public hospitals. The city hospital system thus lost an important source of political support. What it gained were the patients that voluntary hospitals refused to admit, as these private institutions vocally declared that thanks to federal policy, their role as providers of “charity” care was over (Opdycke 2000).<sup>11</sup>

By reading articles in the sample draws, we perceive something not revealed by the network structures — the chaos New York City’s public hospitals of the period were undergoing:

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<sup>11</sup> Both Opdycke and others have State’s 1966 Medicaid program enrolled a large pool of people beyond those eligible by default -- the so called “medically indigent” that states were allowed to define under Title XIX. For one, the fiscal structure of Medicaid in New York was highly unfavorable to both to the City of New York--which became responsible for sharing recipients’ costs with the state-- and to the municipal hospital system in particular, which in turn saw no per patient reimbursement (Phillips-Fein 2017; Opdycke 2000).

overcrowding, severe lack of <sup>12</sup>, fiscal squabbles <sup>13</sup> and militant actions on the part of <sup>14</sup>: Problems familiar from the previous periods appear magnified. (A search of the full 1A corpus reveals that a few stories did indeed link the condition of municipal hospitals to the Medicaid program. Evidently the connection was never sustained enough for it to figure in the semantic network map for 1958 - 1972.)

Would the that some of these events actually occurred in hospitals under the control of the Department of Mental Hygiene have struck readers as relevant? It is quite likely however, the DMH policy during the 1960s played a part in *creating* the strain on the city hospital system. Even during the 1960s, scholars linked the previous decade's initial declines in the state's mental hospital inpatient census to a dramatic increase in readmissions (Brill and Patton 1962). By virtue of the function of the municipal hospitals function as receiving hospitals for the State system, the task their psychiatric services would have been massively increased by these trends as they continued through the 1960s (Gupta, 1970; Smith and Hannah, 1978). Hence, one possible matter of responsibility.

<sup>12</sup> "PATIENTS SHIFTED DESPITE DANGER; Private Hospitals Transfer Critically Ill, Inquiry Told Dr Eishna testifies 1,300 critically ill patients were moved in '67 to Bellevue and Kings County Hosps from voluntary and other munic hosps claiming bed shortage; Dr Henig says beds were available; Dr Coates charges deaths among Coney Is Hosp patients pending transfer; Coney Is aide Dr Schnitzler replies; Comr Terenzio silent; SIC probe chief J Fisch clarifies testimony on \$1-million kept by voluntary hosps"

<sup>13</sup> "CITY ASKS REBATE FROM 4 HOSPITALS; Says \$2-Million Was Spent Contrary to Pacts Procaccino demands return of \$2.2-million from 4 voluntary, nonprofit hosps for expenditures made 'contrary' to affiliation contracts with munic hosps; hosps listed; Maimonides Hosp denial"

<sup>14</sup> "Jacobi Hospital Pediatricians, Protesting City Health Care Fees, Urge Patients Not to Pay Their Bills Pediatricians at Jacobi Hosp urge pediatric patients not to pay their bills as protest against fees of up to \$16 a visit imposed by NYC when Medicaid took effect; say Bronx Munic Hosp Center admr King threatened to suspend drs but withdrew threat when entire pediatric staff said it would resign if 1 were suspended; get pledge from Drug and Hosp Workers to oppose drs suspension; King pledges no reprisals; Deputy Comr Derzon comments"

***Collection 2A: The domain occupied by “mental hospital” in 1945-50***

The second document collection captures the role of government as a guarantor of health. Leds in the collection during the two decades from 1945-1965 appear to have to do with what would today be at least two distinct things: on one hand, to the role of public institutions in health care *delivery*, and on the other medical research of public relevance. Here is the flavor of leds that appear in the collection during the first two decades covered:

*Needed: A Plan For the Mentally Ill; Plea for an enlightened system of public psychiatry to remove a blight on society....*

*181 CENTERS PUSH FIGHT ON CANCER; Drive to Spot Disease Before Symptoms Appear Gaining as Public Realizes Toll FUNDS SHARPLY INCREASED Examiners Seek Unsuspected Cases in Check-Ups*

*U. S. FIGHTS DISEASE THAT BLINDS BABIES..*

It is worth noting that through the end of the 1950s, nearly all the articles in this collection are also included in Collection 2B. In the period 1955-60, there exist only two--simply reading them gives us an easy clue as to the difference between the respective contexts captured.

Collection 2B tracks the evolution of health and medicine. These two articles lend credence to an interpretation of the Collection 2A as oriented specifically to the public role: One is about the New York State Department of Mental Hygiene as an employer, “9,000 STATE JOBS OPEN; Mental Hygiene and Public Works Groups Seek Help.” The other appears to be marginal — — unlike the other articles captured in the random draws this collection, in that



it lacks a health focus. In the case of the second article, the event reported concerns the New York City foster care system. It does however confirm that this collection is distinguished by its specifically public concerns “...City Welfare Official Says Public Suffers if Youths Lack Proper Homes...”<sup>15</sup>

Thus Collection 2A captures something that is hard to name, because it no longer exist in the same way. It captures a health domain that, in 1945-50, is defined by its universality. The domain includes public hospital systems that at least in theory concern everyone, and research of which the same is true.

During the seventies the sample includes no articles at all. The history of the New York City public hospital system touched upon above should prepare us for the disappearance of the municipal hospitals from this context. References to institutions like Bellevue in still appear in the other Collections, but in the events same role. Rather, they either appear in the context of the crisis of a system that only serves the most desperate (Collection 1A), or, as an appendage of a the private healthcare system (Collection 2B).

What then accounts for a reappearance of articles in this collection from the mid 1980s? As it turns out, the same development that swells the size of all the Collections during the same

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<sup>15</sup> The health focus of Collection 2A that is apparent from an interpretation of the articles randomly drawn from it should be hardly surprising when we consult the : notice that until the 1960-65 period, the vectors representing articles. In this collection are, on average at least as close to the model space Centers of the three other Collections -- all medically-focused during this time -- as they are to the 2A Collection's own Center— See Appendix 1 (available from author).

period: AIDS appears. Of course, the discovery of the disease occurred -- and was reported in *The New York Times* -- during the last years of the 1970s. By the latter part of the 1980s only does it appear as a public health concern. Indeed, the repopulation of document Collection 2A would imply that it restores health *as* a public concern, at least briefly.

That said, the relevant institutional context that appears when we reduce Collection 2A is seriously diminished. Figure V-5 shows the semantic networks representing Collection 2A both before and after 1965.

### ***2B : The domain of the mental hospital as it evolves***

Document 2A captures health and medicine, in 1945-50, as it evolves. Recall the strategy we used to generate this collection: it was based on the way that observed language falling within the region as redefined on each aligned period model. Collection 2A's relative continuity on the quantitative measures presented in the Appendix, when compared to the others Collections, should thus be notable.

Figure V-6 displays a river network for Collection 2A. The horizontal dimension represents the ordering in time of twelve overlapping periods: the first spans from January 1945 to



For present purposes two particular streams—that is, historically connected clusters of terms in Collection 2A—bear attention. One is the light blue stream that appears in the first period labeled “City Hospitals + Patient Care”. This concern appears continuous in through the next period-- where the relevant cluster has the same label--and the following one, from 1956 to the end of 1966, where the most relevant terms in the cluster are “NYC Health Dept + NYC Hosps.” In the period that spans from 1961 to 1972, it no longer appears. The role of the New York City hospital system, its perceived public mandate, and the disintegration of that mandate have all been discussed above, in connection with Document Collection 1A. Here they appear in a different context.

In the medical context represented by Collection 2A, we can also note both two separate source “streams” that merge to form and the disappearance of a stream of concern related to mental health. Two separate continuous streams merge in the 1957-61 period. The first is labeled “Research Centers + Mental Illness” (1945 to 1956), then “American Psychiatric Society + National Mental Health” (1951 through 1961). This stream appears to capture contemporary discussion of the activities on the part of the generation of psychiatrists that emerged dominant after World War II and their allies, the national mental health associations. Here find the founding of the National Institutes of Mental Health and its early grantmaking efforts, as viewed from *The New York Times*.

The second stream is labeled “Health program + Medical Society” for 1945-56, and becomes “Mental Health + Pub Health” only in the second period. This discussion appears to reflect what we could call the national healthcare agenda, as it evolves. In the relevant cluster for the first period, which spans the late 1940s, a closer inspection of the component terms reveals that these include “mental health” -- as well as “rehabilitation program”, “Welfare Dept”, “New York City”, “United States” and “health program” -- also “health insurance” and several other references to it. This cluster appears to capture, among other things, the debate concerning national health care, a debate that the AMA, thanks largely to local medical societies dominated (and eventually won).

As distinctive elements of the visible context of health and medicine generally, these streams then merge in the 1960s. The cluster of which they both appear part in the 1956-67 period is labeled “Mental Health and Pub Health,” and then again as “Mental Health and Pub Health,” 1961-1972. In the 1970, the stream dies out. After that point, mental health no longer appears as a sustained concern of the health field generally in the *New York Times*. Note that clusters relating to “Mental Patients + Mental Illness” appear in this context in the late 1980s -- as well as in the most recent period, 2004 to 2015, as “Mental Health + Mental Illness.” These discussions, as the small size of the relevant bars representing the clusters make evident, contain only a few terms.

As part of the context of health and medicine visible to contemporaries, the relevant story begins just as historians of deinstitutionalization would have it: the activities of the NIMH and their allies indeed merge with the national healthcare agenda in the 1960s. That discussion continues throughout the decade and early into the next, then it disappears.

## **DISCUSSION**

The analyses above reveal something that canonical histories of deinstitutionalization omit, or that they are not able to capture: At the close of World War II, mental hospitals were legible as part of a system of public health care delivery -- itself a prominent feature of the medical field. Unlike other countries, the US had never had centralized health planning, but at the end of the second World War state and local government played a fairly important role in the health care system that existed. This was true in New York, but also no doubt in other localities across the US that relied on city and country hospitals throughout the first half of the twentieth century (Hollingsworth 1986, 78-81).

Histories of mental health's transformation have sometimes remarked upon the optimism with which the public viewed psychiatry during the forties and fifties. A few have linked this optimism to the discovery of new drugs, and the promise--implicitly foolish--that like tuberculosis and polio, a cure might eventually be discovered for mental illness. However,

these same historical accounts have not devoted attention to the broader medical context in which mental illness would have been viewed from 1940s into the early 1960s.

The end of the war saw major new federal investments in medical research. They would have appeared against the backdrop of a delivery system in which state and city-run hospitals had and continued to play a significant role. Much of this research would have been done within those same public institutions. In New York City as in other metropolitan areas, public hospitals were important as affiliates of universities-- they were the sites of many of the medical breakthroughs of the period (Hollingsworth, 1986, 80-81; Ludmerer, 1986; see also Kolb, 1962). The relative fortunes of the city's public hospitals declined with the growth of third party health insurance; their voluntary and private counterparts had both greater freedom and greater incentive to take advantage of this new potential revenue stream (Starr, 1982; Opdycke, 2000). It was thanks to these innovations, in conjunction with federal for hospital construction introduced in 1946, private and voluntary hospitals grew so rapidly during these years (Statistical Abstract of the US; Starr, 1982), this growth however did not happen in a vacuum. It happened in the context of a public role in health that no longer exists. Through the 1950s, as the costs of hospital care doubled, New York's municipal systems continued to feature in this context. Particularly in cases of medical emergency, government-run institutions continued to be where a large proportion of middle and working class Americans received medical attention. Alongside this system for general medicine with general

relevance, existed public hospitals for “chronic disease,” including infectious diseases and mental illness.

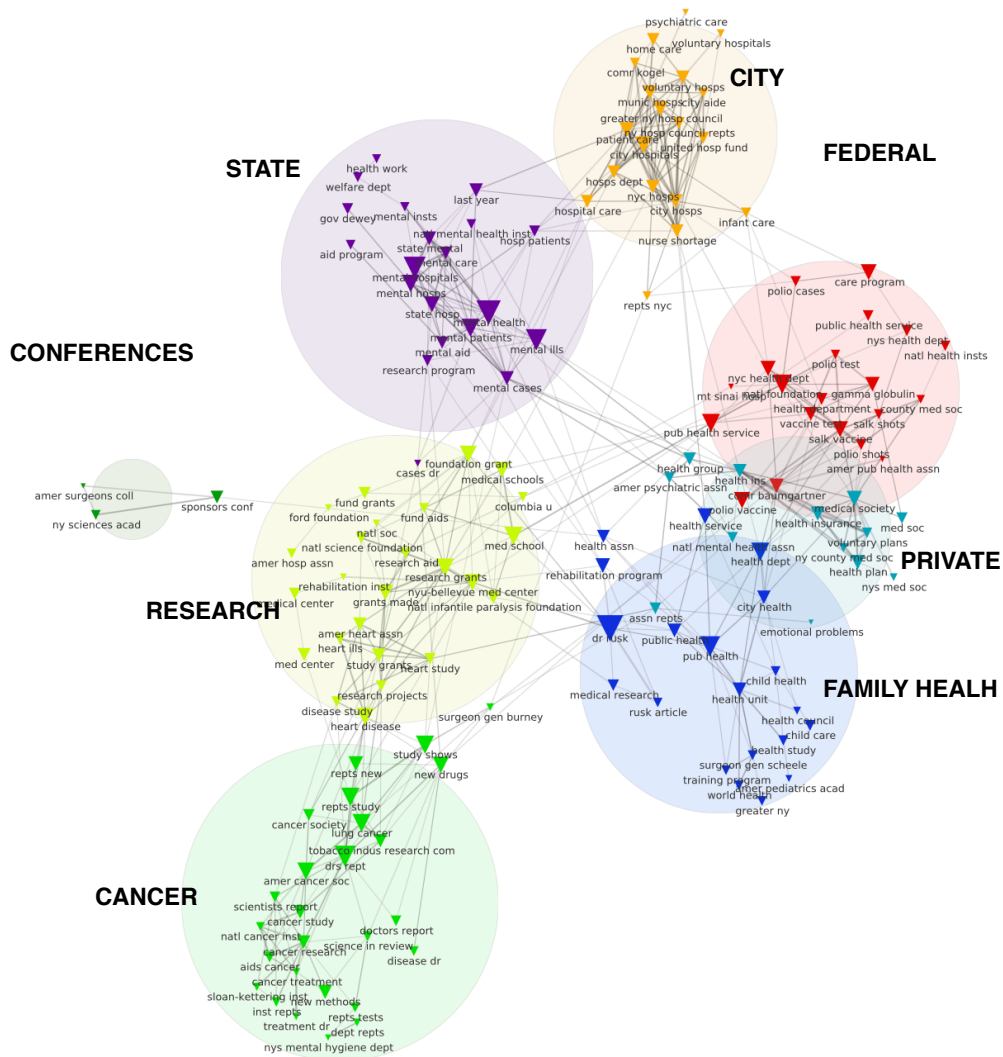


Figure V-7.

The context of health, seen from *The New York Times*, 1945-1960.  
Pooled Collections (1A, 2A, 2B).



Of course, the context for the mental hospital as it was visible to a lay newspaper readership during this period may not have mapped to perceptions from within the field (Abbott, 1981). Psychiatry had traditionally been a marginalized speciality within medicine. Retrospective scholarly accounts describe the difficult position of state hospital physicians that resulted from their dual role as public servants (Grob, 1983). (For what it is worth, contemporary sociological treatments of mental hospital superintendents during the thirties, forties and fifties do not seem to have made much of this tension (Belknap, 1956; Rowland, 1938)). The pressures felt by staff doctors at municipal general hospitals of the period could not have been totally dissimilar (see Opdycke, 2000: ch 4). It may indeed have been this professional experience that organized medicine sought to avoid on behalf of its membership, with its campaign against “socialized medicine” during the late 1940s (Starr, 1982).

The initiative of the AMA was key both in blocking the passage of Truman’s universal healthcare plan, and subsequently, in Starr’s account, developing the policies on which the “interior” provisions of Medicare and Medicaid were modeled (Starr 1982, 280-286; 370-378). Both programs represented massive infusions of funding to pay for medical care, with relatively few constraints on the existing prerogatives of private providers. As discussed in Chapter Two, they thus played an important part in the transformation. In the discussion above, I noted a variety of the consequences of the transformations on the contexts of events that contemporaries could perceive. Taken together, the analyses presented here reveal two major changes in these contexts, accelerating from the mid 1960s.

First, *the public role medicine receded from view*. The analysis of Corpus 2A revealed the visible role that government had played as a *universal* guarantor of health in the 1940s-- this context disappears completely by the end of the 1960s. We observed something similar in the evolution of coverage of New York's municipal hospital system as they appear in Corpus 1A, part of the evolving context of the state mental hospital system. During the sixties the municipal system appeared in that connection as having less and less to do with health, and more and more to do with the poor. The semantic river network based on Corpus 2A shows that by the period ending with 1967, the stream representing the municipal hospital system has dried up: though the city hospitals continued to exist, they disappear as a medical concern. The unprecedented government investment in medical care represented by Medicare and Medicaid thus appears to have had a paradoxical effect: they helped to make the *public* role in health invisible.

The second notable transformation is that starting in the 1960s, *mental illness begins to fade from view as a medical issue*. This is true both in the sense that as deinstitutionalization in New York State preceded, the context of the mental institution appeared increasingly divorced from that of medicine. Analysis of Collection 1A revealed this, illustrating how mental hospitals retained their connection, for contemporaries, with the city hospital system--itself in crisis and rapidly losing any universal relevance (per Collection 2A).

But the transformation was not limited to the mental institutions themselves. It would be tempting to imagine that with the expansion of third party health payment that abetted an uneven exodus from both state and city institutions, mental health would have appeared increasingly central to health care in general. Instead the opposite occurred. We see this clearly when we examine the river network representing the mainstream of health and medicine from a contemporary standpoint. As Collection 2B showed, by the early years of the 1970s, *mental health disappears a distinctive part of the medical field*.

That would have been last moment, I contend, that a movement on behalf of the mentally ill had a viable target. By the middle of the 1970s, there is simply no visible “part” of the healthcare field around which mental health advocates might have leveled new demands -- ones that might have attracted more fruitful and enduring sources of support. Mental health workers, for example, come to mind. Brown and others have noted that mental health advocates never really organized support of this constituency (Brown 1984); however in New York it appears that Office of Mental Health employees were strong enough to prevent hospital closures into the early 1980s (Weddle 1998).

In the late 1960s, mental health still appeared as a distinct part of the medical field. It still had obvious connections -- the relevant cluster of coverage on the river network reveals -- both to New York’s city and voluntary hospitals on one hand, and on the other to federal agencies like NIMH and national membership organizations like the NAMH. Meanwhile the friends and

supporters, of both of mental health, mostly qua psychotherapy (Kadushian 1969), and of the mentally ill--as archetypical victims of society's intolerance for deviance, were apparently multiplying. What were those friends and supporters doing?

In an account of the breakdown of the peasant way of life in rural *Bearn*, Bourdieu describes a set of marriage practices that had, traditionally, appeared rational on the collective level. Everything about peasant life in the early years of the twentieth century ensured that the right people married each other; just as naturally and eventually, they took over the operation of family farms. With changes in those circumstances, initially so minor from the standpoint of the peasantry that they hardly mattered, these same traditional *Bearnais* marriage practices came to appear self-undermining. "Whereas formerly, because it was integrated into the coherence of the system," Bourdieu writes, the traditional approach, "prevented some marriages only so as to favor others, everything now takes place as if economic necessity exerted only a negative effect, preventing without favoring" (Bourdieu 2002: 50). The movement on behalf of the mentally ill during the late sixties and early seventies confronted a different outmoded problem. But it appeared similarly self-destructive.

During the 1960s the "mental health movement" largely *advocated* demedicalization. In ignoring the broader medical context that mental health left behind during the 1960s and 1970s, historians of mental health are hardly unique. In many way, they have hewn to the self-presentations of the subjects in their field-- or perhaps the latter's aspirations. The use of

the “term ‘medical model,’ “ in the field of mental health over the past two decades, recalled Jack Ewalt, former State Mental Health Commissioner of Massachusetts and a psychiatrist of the NIMH generation, in 1979, was “of varying and always imprecise definition but invariably pejorative as used.” (Ewalt 1979: 508)

During the 1960s attacks on the “medical model” among mental health’s friends, supporters and potential movement-makers were indeed prevalent. As Ewalt acknowledges, they were certainly rhetorical, but not strictly so. Ewalt himself identifies attacks on medicine (or “medicine”) with new professionals entering the field of mental health; including psychologists and social workers (see also Bardach 1972; Kadushin 1969); as well as “well meaning social scientists” (Ewalt 1979: 508).

Many of the best-organized former state hospital patients groups were opposed to the medicalization of mental illness, which that they saw as having justified their confinement. “‘Ex-patient’ was a controversial term because it appeared to embrace the medical model,” recalls one activist (Chamberlain 1990: 323). The civil libertarians and lawyers who were the ex-patients’ sometime allies during the 1970s would have agreed (Rothman and Rothman 1970).

Finally, there are several important senses in which psychiatry and psychiatrists *themselves* turned their attention away from medicine during this period. The rise in popularity of

humanistic psychotherapy is one. Kadushin writes in 1969 of “the ‘return of psychiatry to the mainstream of American medicine’,” the quotes are unattributed in original, only to note the irony of the fact that psychiatrists, many of whom were then engaged full time in talk therapy, were now forced to take a position on whether non-psychiatrists should be permitted to do so as well (1969, p. 335). Torrey argues that the infusion of federal support for mental health--most notably the creation of the NIMH as a federal agency independent of the NIH- oriented the leadership of organized psychiatry away from its ‘parent’ profession, believing that so consecrated, the once under-appreciated specialty could “go it alone.” (Torrey, 2015, chapter 4)

The strategy—insofar as demedicalization can be considered a strategy, on the part of a movement for the mentally ill—might have appeared successful for a time. Particularly in places like New York, where the “Friends and Supporters” were many, and where social welfare was relatively generous.

But of course, it ultimately failed. In 1973 New York’s Department of Mental Health proposed to reimburse communities in full for the costs of the care of the mentally ill it had institutionalized. But by 1975 all bets were off, as the state actually *was* facing serious uncertainty, owing to New York City’s fiscal crisis (Phillips-Fein 2017; 191-192).

The disappearance of mental health from medicine in the 1970s was as ironic as the disappearance of the “public” role in health during the 1960s. Neither was the institutional change it appeared to be. Both were conditioned by developments that shifted resources on an unprecedented scale on the basis of medical need: the growth of a healthcare market based on insurance, and the expansion of federal subsidies that, if not universal, redistributed resources specifically for medical care on behalf of a very large population— through this very market. As we saw in Chapters One and Two, these were not peripheral developments. They are at the very center of any plausible account of states’ abdication of their traditional role in the care of the mentally ill.

Why was the role of medicine not perceived? For one, as we have seen, medical programs grew amid a raft of other expansions of federal welfare provision in the 1960s. Second, as Paul Starr points out that during the 1970s there were other calls to de-medicalize, from the feminist movement, for instance—partly a reaction, Starr suggests, to the infelicitous features of the market-based system of medical care. In any case, those who advocated on behalf of the mentally ill were not alone. Even in the 1980, scholars could characterize the growth of the disability rolls the solution to a *distributive* dilemma—“How can people be given an incentive to save and economic security at the same time?” (Stone, 1985: 17)—without remarking on the specifically *medical* component of this redistribution, as instituted in US policy.

Whether because of the political advantages associated with delivering medical care (Starr 1982; Pierson 1995), or the power of the markets they helped to grow, the federal policies of for both health and medical disability have, as of the time of writing, survived multiple attempts at social welfare retrenchment that other programs did not. Could the mental health movement have refashioned demands around another, non-medical target? Perhaps. In any case, a different basis of support for the mentally ill was never discovered.

The eventual reorientation around the “consumer” movement in mental health during the latter part of the 1980s implicitly recognized the failure of demedicalization in sphere of political economy. (Again, terminology was contested: some more radical ex-patient groups insisted their movement should be a “Consumer/Provider” movement, as the sharp role distinction between patient and professional was -- still -- unwarranted (Chamberlain 1990)). In fact when they arrived their old friends the psychiatrists were already there. The profession came back to medicine came even earlier; according to Greenberg’s account, starting in the 1970s (Greenberg 2013).

If the embrace of medicine could have worked for the mentally ill, it came too late. As we saw at the end of Chapter One, by the time that ex-patient groups discovered themselves politically as consumers of health care, they were already in the course of being discovered. Their discovery both by actors in the private delivery system that had come to surround them,



as well as those actors' organized opponents, hamstrung the mental health consumer movement.

Conversely, as Ewalt pointed out, perhaps a bit sardonically, in 1979, many “equate the medical model with a pyramidal structure of authority in health care agencies. This concept historically has [some] validity, *but no relevance in current health care delivery*. Multiprofessional, nonprofessional, consumer, and legislative bodies all play their role” (1979: 514; emphasis added). The healthcare market that replaced public hospitals had little use for the culture of medical authority.

## CONCLUSION

The mental Consumer movement in mental health arrived too late, under circumstances in which it had little significance.

Following the end of the second world war, employers and unions competed to provide medical care to workers and their dependents. Resources also flowed to medicine from the federal government. Part of the flow--an increasing part, over the 1960s--was directed to states, who were given discretion in organizing its distribution on behalf of individuals. Up through the 1970s, federal resources were on offer, even from a Republican administration, for the medically disabled. Could the movement on behalf of the mentally ill have acted again to secure them?

Put differently: in the market-based healthcare system that emerged, could the mentally ill have threaded a less unfavorable path? Barring the existence of a much broader progressive mobilization in which the mentally ill might have participated-- on some other basis -- the medical field would appear to have been their best target. And yet instead throughout the sixties and seventies, up through the early 1980s potential elements of such a movement would appear only increasingly to be bent on undermining such its chances of success as they embraced de-medicalization.

In the previous Chapter we put the disappearance of a mental health system from the field of medicine in the early 1970s. That would have been the last time that a movement on behalf of the mentally ill had a target, around it might potentially have reorganized itself. This historical horizon permits analysis of the movement as a collective actor. A fully adequate analysis is beyond the scope of this work. Hopefully some part of the dissertation has helped make a more complete study possible. But in closing, let me give a brief sketch.

The artist Liam Gillick uses the trope of “the day before,” as a way of revealing what is invisible from a given standpoint in history. (“The day before the mob became the workers. The day before the factory closed. The day before Hotel California was released – the idea of a French bar in the middle of nowhere, with nothing to listen to and everyone waiting for the arrival of the ‘soft’ future.” [Gillick 2006]) We can now finally ask what was the failed movement on behalf of the mentally ill looked like, *the day before* it lost its chance to be a different one.

To capture this, let us descend to the level of the event—or to a string of events. Here they are as they appear, part of the visible context of deinstitutionalization as reported in *The New York Times*, captured in Collection 1A:

*BRONX HEALTH UNITS SHUT AFTER REVOLT Lincoln Hospital Mental Health Service, a community project with clinics in and near the South Bronx hospital, was ordered closed last night following its seizure by more than 100 nonprofessional employees.*

*LINCOLN FACILITY IN BRONX REOPENS; But 100 at Mental Health Center Continue 'Action' The Lincoln Hospital Mental Health Service officially reopened yesterday, but at least 100 protesting workers continued their community action and refused to take orders from Dr. Harris B. Peck, the administrator.*

*23 SEIZED AT SIT-IN IN LINCOLN HOSPITAL Twenty - three persons -- psychologists, social workers, nonprofessional workers and medical students -- were arrested yesterday afternoon at Lincoln Hospital Mental Health Services during a sit-in on the 18th day of dispute over control.*

The events took place over three weeks in March 1969. The protest at a community mental health clinic in the name of “real” community control, not only attracted significant support of the residents of the Bronx neighborhood in which it occurred; it drew the attention of radical groups across the city. Both Black Panthers and SDS visited to voice their solidarity with strikers and community.

The result appears on the face of it to have been entirely inconsequential: the three Directors of the Center resigned. In the writing of historians, however, the events appear as helping to discredit the concept of community mental health (Torrey, 2013, p. 70; Grob, 2014, p. 256).

Of course, only a scant six years previously “community mental health” had been the basis of the first ever national mental health policy. Over the course of the 1960s, one comes across frequent efforts organized under such auspices -- unsurprisingly, they often appear designed to attract resources to poor neighborhoods (see archetypically, Kellam and Schiff, 1966). But indeed from the seventies alongside the other more and less coherent groups that appear-- progressive and radical psychiatrists, other new mental health professionals, ex-patient groups, public interest lawyers -- community mental health advocates increasingly absent in the history of mental health movements (McQuiston and Rosenheck 2006).

The conflict at Lincoln could attract wide attention--including the continued attention of *The New York Times*-- partly because the experimental mental health centers program at the South Bronx hospital was already a legendary success. In 1964 a contract between the NYC Department of Hospitals and the Albert Einstein School of Medicine established a Mental Health Service at Lincoln Hospital, to be associated with a new Department of Community Psychiatry. The Neighborhood Service Centers program, started the following year with funding from the Office of Economic Opportunity, was a credit to the psychiatrists involved in founding it. Thanks to their avid documentation of their success, we know a fair amount about how this particular community mental health program looked.

The idea was to deliver mental health services through storefront walk-in centers in the South Bronx, an “area with a high level of pathology” that sent residents to the Department of Mental Hygiene system at a rate 40% higher than average. The Service Centers would effectively screen residents for signs of mental illness, that could be treated outside of state hospital care. They would be directed by psychiatrists, and staffed by “indigenous nonprofessionals” (Hallowitz, 1968, p. 706; Rieff et al., 1967). The arrangement was “extolled as the solution to the serious manpower problems,” in mental health care (Shaw and Eagle, 1971, p. 257). And indeed, as one of the founders notes enthusiastically, the cost of employing all twenty or so of these local residents of the largely Puerto Rican Bronx

neighborhood, amounted to less than the salary of a single staff psychiatrist yearly (Rieff, 1967).

The idea, as developed by the Neighborhood Service Centers' founders, was that "anyone in the neighborhood may walk into a center, and immediately talk to someone about his concern, and get some degree of assistance." "The first contact is not with the receptionist but directly with the indigenous nonprofessional who is the main service agent." (Hallowitz, 1968, p. 705)

What did that mean? The Lincoln Mental Health Center workers left no manifesto, so we don't actually know how they saw this. But some detail on what they actually did is available through the writing of the program's founders: They mediated the domestic disputes that had precipitated suicide attempts. They helped the mothers focus on problem children, by assisting them in securing welfare benefits. And they handed over to psychiatrists (only) the cases they thought the latter could handle (Hallowitz, 1968; Hallowitz and Riesman, 1967).

Reading articles published over the course of a few years illuminates something of the touted success of the Lincoln project. The aspirations of the founding psychiatrists on behalf of the paraprofessionals, which had sounded not a little condescending in their initial delivery, really *worked*. The people that the Neighborhood Service founders had hired as mental health aides took on their new roles. They appear to have acted confidently and fairly creatively on the message of their employers that they were providing an "important [] treatment service" of

“potential value that goes far beyond that of a port of entry into the service system” (Hallowitz, 1967, p. 706).

What precipitated the crisis at Lincoln? The administrators’ account of the “explosive strike”—given in the context of their resignation—it is barely intelligible (Roman, 1969, p. 4).

Their apologia offers no coherent explanation of the conflict’s source. At an NIMH sponsored conference in Tampa the same year, however, former members of the psychiatric staff at Lincoln sought to clarify what the sole published narrative of the Lincoln strike had left out (Shaw and Eagle, 1971, p. 255).

The proximal cause of the events was the discharge of four of the mental health workers.

Shaw and Eagle, the former Lincoln psychiatrists, report what the events themselves made obvious: the organized response revealed existing tensions that had been simmering between the founding administrators of the program and both the professional and paraprofessional staff of the Lincoln Mental Health Service. They also give an account of how the “action”—not a classical labor dispute—became a “strike,” when the administration responded by punishing participants, professional and nonprofessional, alike.

What seems to have brought the two groups together around the issue of “community control,” is their opposition to the administration’s plans to change the nature of Mental Health Services at Lincoln. Having labored to craft an application to the NIMH for a

Community Mental Health Centers Staffing Grant, which in 1968 they finally received, the founding psychiatrists revealed plans to turn the experimental Center into something that looked much more like a traditional inpatient psychiatric service (Shaw and Eagle, 1971).

Protests at and around Lincoln were thus animated by the lack of community input in the writing of the grant--that is, the grant whose consequences had displeased the professionals and the paraprofessionals both. The middle class professionals, Shaw and Eagle's account makes clear, had been attracted to Lincoln precisely because of its experimental program. The indigenous nonprofessionals had, over the past four years, been largely self-directing. They had been told they had an important new job that promised great things -- and advancement of who-yet-knew what kind—and they appear to have come up with ways of doing it. They were in 1969 being faced with the prospect of becoming unskilled mental hospital attendants, a job for which not all would even qualify (Shaw and Eagle, 1971, p. 260).

Of the observations about made by Shaw and Eagle, one stands out as particularly astute. The staff psychiatrists at Lincoln had been very close to dislodging the administration before. In these previous conflicts “professional staff had not hesitated to seize power [...] but they could not seem to hold on to it.” It was in this situation that “indigenous mental health workers could claim to represent the community” (1971: 258).



As a way into the mental health movement the day before it failed, there are several things that make the Lincoln Hospital incident notable.

One is the position of the Lincoln mental health workers. Shaw and Eagle's observation that the so called "indigenous nonprofessionals" were the key element of the Lincoln struggle is indeed crucial; so too their recognition that of the parties involved, they alone could plausibly claim to speak on behalf of the community. This was quite obviously true from the standpoint of the racial politics of the South Bronx at the time. It was also true with respect to the "known low level of success of mental health professionals with the poor," (Shaw and Eagle, 1971, p. 250). Whatever the Lincoln Community Mental Health workers had been doing, it had at least temporarily reduced inpatient admissions, while successfully identifying people that both they and the professionals believed needed psychiatric help (Hallowitz, 1968). They had also evidently done so in such a way that when the standoff at Lincoln occurred, representatives of "the community" not only knew who to support, but were vocal about it.

The absence of workers in struggles on behalf of the mentally ill is the focus of Brown's analyses of the movement a decade and a half (Brown, 1984). Through the late 1970s and into the 1980s it appears that the efforts of public employees kept virtually empty mental hospitals open, at least in New York State (Weddle, 1998). But in that later context, organized mental health workers and the organized mentally ill, did not appear to be on the same side of any movement.

Thus in 1969 the Lincoln Mental Health workers were in a surprisingly strong position. So were mental health workers in the New York metropolitan area generally. Only a few months earlier, attendants at four area state mental hospitals walked off their jobs -- in violation of the recent state law permitting them to bargain collectively. The mostly black and Puerto Rican attendants were displeased with their representation by the union of upstate hospital workers, also the preferred bargaining partner of the Department of Mental Hygiene. They instead wanted to join SCME, which at the time represented some 85,000 municipal workers (Odycke, 2000, p. 125-127). *The New York Times* also covered *that* action amply -- albeit a far more significant disruption than at Lincoln, involving some 10,000 workers in hospitals that housed 13,000 patients (Lafave et al., 1969). The paper's editorial coverage cheered on the attendants--the real "friends" of the mentally ill, and the de facto caregivers to the unfortunate population confined in state hospitals--from the sidelines. After a resolution in SCME's favor, the paper ran another editorial celebrating the Taylor law for having enabled the state employees organizing effort -- never mind that their action had technically *broken* the law.

The significance of the surprisingly strong position of the mental health workers in the Lincoln events—possibly beyond it—was, however, shaped by the responses that followed in its wake.

The “NIMH, which had watched the events in horror, tried to disassociate itself from its model center as quickly as possible,” claims E. Fuller Torrey, an employee of the agency at the time, recalling the events in 2014 (70). Clearly some psychiatrists *were* horrified at that a demand for community control would be turned against the well-known and famously progressive clinic’s Directors, and even result in their ouster. Hence Shaw and Eagle’s attempt to address the facts of the matter at the NIMH conference later in the year.

It is their role as mediators that is more interesting. Theirs, and the part played by the of the sixty-seven other professional workers who joined the strike action, would seem arguably to have more to do with the historical verdict on the event that critics like Torrey hand down.

Shaw and Eagle pointed out to their colleagues in Tampa that Lincoln’s directors had justified their exclusive control over the grant-crafting process by continually describing the community around Lincoln “as unorganized and in a state of chaos.” They had rejected collaboration with local leadership “described in Mafia-like terms,” and instead rushed to get the grant through NIMH alone -- claiming that the jobs of their current employees depended on a continuity of funding. Shaw and Eagle pointed that other local Bronx “[o]rganizations like the Hunts Point Multiservice Center could write and obtain grants as large as 3-million dollars for a health center” (1971, p. 261-262); and that this attitude was uncalled for.

“It is our conviction,” reads the young psychiatrists’ published talk, “that a combination of colonialism and racism led to the crucial act that started the crisis of the spring of 1969. This act, “they continue, “consisted of submitting an application for a community mental health center staffing grant” (1971, p. 262), “whose guidelines were interpreted by the representatives of Federal, state, and city governments in such a fashion” that they could only result in an unacceptable model of mental health work for all involved (1971, p. 259). Did Shaw and Eagle or their audience see an astonishing shift in the interpretation? It was not now not the racism and colonialism of the program’s administrators, of but *the staffing grant itself*, that had put the events at Lincoln in motion.

The unacceptable model, of course, was the medical one. Shaw and Eagle quote the recent work of their colleague Salvador Minuchin, characterizing the events as, ““a conflict inherent in the attempt to introduce paraprofessionals into the delivery of services while trying to maintain the traditional conceptualizations of mental illness, which carry the implicit idea that nonprofessionals cannot heal”” (Shaw and Eagle, 1971; Minuchin, 1969).

Shaw went on to a job on the west coast; Eagle remained employed at the Community Psychiatry Department at Albert Einstein. Despite the apparent success of the Lincoln occupation at achieving its goal in removing the program’s leadership, there is no published evidence of what happened to the Neighborhood Health Centers or indeed to the Lincoln Mental Health Service subsequent to the 1969 events. In 1970 there was another occupation

at Lincoln, this time including nonprofessional and medical workers across the hospital's departments. Demands for worker-community control were renewed. As similar struggles continued to play out at the South Bronx hospital during the early 1970s, Lincoln became the focus of emergent citywide health justice organizations like Health/PAC (Chowkwanyun, 2011). Their movement found itself in the ironic position, in 1975 when New York's fiscal crisis threatened its public institutions, of defending the municipal hospital system that had been its target (Phillips-Fein, 2017b; Chowkwanyun, 2011).

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